IN THE MATTER OF AN INTEREST ARBITRATION ESTABLISHED PURSUANT TO THE BINDING ARBITRATION FAMEWORK:

HIS MAJESTY THE KING IN RIGHT OF ONTARIO
(as represented by the Ministry of Health)

(the "Ministry")

- and –

THE ONTARIO MEDICAL ASSOCIATION

("the OMA")

BEFORE THE BOARD OF ARBITRATION:

Arbitrator: William Kaplan
Ministry Nominee: Dr. Kevin Smith
OMA Nominee: David Wright

May 6, 7 and 8, 2024

INTEREST ARBITRATION BRIEF OF THE MINISTRY OF HEALTH

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1. INTRODUCTION

1.1 Overview

1. The Ministry of Health (the "MOH" or the "Ministry") recognizes and values the vital health services that physicians provide to the residents of Ontario. Physicians are the most highly educated and highly skilled providers of health care services in the province. Physicians are independent contractors (not government employees) for important medical services and the government pays for these services through our single payer Ontario Health Insurance Plan (the "OHIP"). As set out in the *Health Insurance Act* (Ontario) (the "HIA"), all medically necessary services are compensated through the provincially administered health insurance program in order to qualify for funding from the federal government under the *Canada Health Act* (the "CHA").

2. One of the key objectives of the relationship between the MOH and the physicians represented by the Ontario Medial Association (the "OMA") is to determine the terms and conditions for the payment of medical services in a manner that ensures patient care and patient access within a sustainable and publicly funded health care system. This focus is captured in the first criteria of the Binding Arbitration Framework (the "BAF") (**Exhibit 1**) which is reproduced below:

> (a) The achievement of a high quality, patient-centered sustainable publicly funded health care system

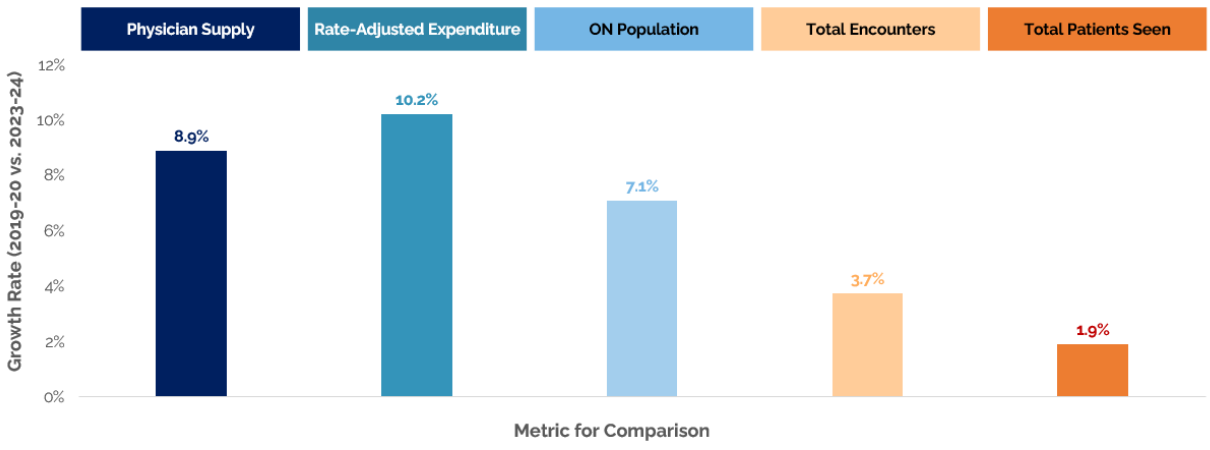
3. The sentiment and purpose of this criterion goes beyond the valuable contribution of physicians to this essential objective. The fact of the matter is that our health care system involves many qualified service providers including Registered Nurses, Nurse Practitioners, Pharmacists, Registered Practical Nurses, PSWs and many, many others.

4. Physicians are the most trained, most skilled and best compensated among the many highly skilled and trained health care providers and professionals engaged in our publicly funded health care system.

5. While it goes without saying that physicians must be an integral part of a high quality, patient-centered and sustainable publicly funded health care system, the system relies on a number of primary and secondary providers to ensure patient needs are met, and that the burden is not entirely on physicians from either a fiscal perspective or from a scope and range of practice perspective.

6. All other health care providers are highly skilled and trained and the MOH must always assess patient outcomes and access, with fiscally responsible alternatives to achieve its objectives. Physicians in Ontario have a high degree of independence and discretion that distinguishes them from other health care providers. We ask the Board to remember this context as it reviews the evidence placed before it. For example, since physicians are not employees, they can determine their hours of work. They are not employees with fixed hours that limit their income. Additionally, they can have the freedom to change and supplement their practice patterns, providing the scale of services they prefer, without limitations.

7. The practice patterns and the scale of physician services have been changing. While we will be reviewing this evidence in greater detail later in the brief the following bar chart[1] captures the changing physician practice patterns:



The following sources and methodology was utilized for the 2019 to 2023 Growth Metrics:

1. Price-adjusted billings removes the impact of fee increases to isolate only the expenditure growth driven by increased utilization.
2. Physician supply and Rate-adjusted expenditure 2023-24 is projected from the first six months of the year.
3. ON population is captured as of Q2 of the fiscal year.
4. Total encounters and total patients seen is captured as growth from Q1-Q2 of 2019-20 to Q1-Q2 of 2023/24.
5. Expenditure calculations include FFS + Shadow Billing. Rates are held constant at FY19 to derive rate-adjusted expenditure.
6. Total patients seen capture all distinct patients with >0 visits in Q1-Q2 of the fiscal year.

8. We note for the Board the following conclusions derived from the above. Over the past four years:

    1. The number of physicians in Ontario has outpaced population growth. The government has planned for physician growth to continue in order to address population growth and physician attrition due to retirements. See Exhibit 2 on the expansion of medical seats.

    2. The growth in physician expenditures (with price removed) has increased more than the number of physicians.

    3. The total number of patient visits has not increased in the same proportion as the number of physicians or population.

    4. The number of unique patients seen (at least 1 visit per year) has not increased at the same rates as the number of physicians or the population.

9. At the macro level, this reveals a number of things. First, it shows that expenditures are growing per physician even without price increases. Second, it shows that the increase in expenditure is not due to more visits from patients or, for example, from a greater number of patients being enrolled under the care of a family physician (i.e. attached patients per physician). In fact, costs per physician are increasing while average visits per physician are decreasing.

10. The evidence illustrates that this same evolving practice pattern noted above has been the case for many, many years.

11. Again, physicians are not employees and to date the MOH has not been able to negotiate substantive mandatory service levels with the OMA. In the last round of negotiations, for example, a proposal to require a minimum number of patient visits per week was rejected. Instead, the parties negotiated an aspirational target level of activity.

12. Therefore, we respectfully submit that it is self-evident to the policy makers in the MOH and Government that **additional solutions** (including but not limited to team based care), to meet the Government's policy objective of greater patient care and more attachment of patients to a primary care provider - all in the context of a high quality, patient-centered sustainable publicly funded health care system must be found. We will illustrate later in this presentation that transformational changes are already underway.

13. These considerations are particularly relevant when the Board considers issues such as retention and recruitment of physicians. There is an entirely different consideration for this hearing than there was in the recent health care decisions in hospitals.

1.2 The Parties

14. As noted earlier in this presentation, with a few exceptions, nearly all physicians are independent contractors, whether they bill for each service provided in a traditional fee for service ("FFS") system or they're renumerated in connection with the various contract models that provide for physician compensation. Even in a hospital setting, where there may be various approaches to remuneration, physicians are not employees (with a few exceptions). Instead, physicians are independent contractors and will work within business groups providing a service as an independent contractor. There are major distinctions between the vast majority of independent contractor physicians and employees under an employment economic model, and these will be described further in the section that follows.

15. The MOH's primary role is to fund medically necessary services. Payments for medically necessary insured services in Ontario, as required by the CHA, are provided under OHIP. The HIA and its regulations provide for coverage to all residents of Ontario against the costs of insured services on a non-profit basis and on uniform terms and conditions. Ontario maintains direct responsibility for the administration and enforcement of OHIP.

16. All insured physician services are prescribed under the HIA, predominantly in regulations under the Act. A physician service is insured if it is medically necessary, referred to in the regulations, more specifically the Schedule of Benefits for Physician Services (the "Schedule") (incorporated by reference into the regulations), and rendered in the circumstances and conditions set out in the regulations including the Schedule.

17. Generally speaking, insured physician services as set out in the Schedule include diagnosis and treatment of medical disabilities and conditions, medical examinations and tests, surgical procedures, maternity care, anesthesia, radiology and laboratory services, immunization, injections and tests.

18. The Schedule is comprised of rules of general application to all listed services as well as rules that apply only to specified groups of listed services. Services are typically grouped by medical specialty and subspecialty (for example, Obstetrics, Diagnostic Radiology).

19. The formalized negotiation process for physicians' fees and related matters between the Ministry and the OMA is described in more detail below.

1.3 Important Distinctions in the Physician Contractual Relationship versus the Traditional Employment/Labour Relationship

20. It is important for this Board to note that this arbitration is not set in the context of a conventional employer-employee relationship. Unlike a conventional employer-employee relationship, the Government is not the employer of physicians and does not exercise control over many of the significant elements of medical practice that impact patient care, access and costs. The Arbitration Framework is different from a traditional interest arbitration process in important ways. The Board should, in our respectful submission, recognize the benefits to physicians of this independent contractor status. At the same time, this model presents a challenge to Government in achieving an excellent, cost effective and patient centric health care system in an environment where it has a distinct lack of direct control over choices made by physicians that impact health care access, quality and efficiencies and cost.

21. Terms and conditions of employment for unionized employees who provide health care services in Ontario are generally determined by collective bargaining and, in many cases, interest arbitration. These conventional labour relations processes are built around the concept of an employment relationship between an employer, employees and their union. Collective bargaining and labour arbitration are predicated on the idea that employees cannot control their wages, hours of work, or working conditions without concerted efforts and legislative assistance. Without these processes, employees would be subject to the common law and the labour market.

22. The contractor relationship enjoyed by physicians is materially different from the typical employment relationship. Physicians in Ontario are not subject to the typical market forces. Their professional practice work is compensated from the public expenditure without any limit. They conduct business on their own account and are free to set their own total compensation and, often, hours of work. They are also free to decide where they work. Doctors in Ontario are not required by government

to relocate in order to respond to regional demand for service. The Government has little to no control over many of these elements.

23. Due to the evolution of public healthcare policy in Ontario, it is the current unique state of affairs that physicians hold a material portion of the power and control traditionally held by employers, while retaining the remuneration for service traditionally granted to employees. Any arbitration award for Ontario physicians must recognize that the physician compensation model is not an employment model, and must account for the differences between the two. A few major distinctions between the vast majority of physicians under the contractor economic model and employees under the employment economic model are set out below.

24. Physicians have greater control over their own work practices and the ability to scale their services than do employees. Employees receive direct supervision and are directed as to the work they are to perform.

25. Physicians cannot be laid off by Government. Physicians have a license to practice and Government cannot revoke that license in the same way an employer can lay off employees. Government cannot ‘downsize’ working physicians to meet budget targets, and therefore they enjoy a superior type of job security.

26. Physicians cannot be “fired”. Even if a physician is faced with the threat of loss of privileges at a hospital, they have access to the Canadian Medical Protective Association which provides legal counsel to vigorously advocate for them.

27. Physicians largely have a monopoly on their chosen work. Only physicians bill the schedule of benefits for the services they provide. For many of these services, only a licensed physician can perform them or receive compensation for them as an insured service. Even when residents (under the supervision of a physician) perform some medical services, the supervising physician bills for the services performed.

28. Unlike typical employees, physicians have far more latitude with respect to their hours and schedules of work. While certain capitation compensation models do

have identified and required hours of work, it is an individual physician's choice to be compensated on that model versus simple fee for service. Even within those capitation models a physician can decide their own work-life balance by enrolling a significant number of patients or very few patients. Their hours of work and workload are modified accordingly. Further, those capitation models require the hours of work at the group level, not the level of the individual physician. As such, these physicians can choose to organize their business with other physicians and share the required workload, thereby maximizing their independence. Employees do not have the luxury of choosing work hours. The employer sets the hours of work and employees typically work a full day or full week of work.

29. Physicians have significant discretion in the determination of their level of income. Decisions regarding the amount or level of services largely rest with the individual. This opportunity for increased income is typically not available to an employee. It is important to note that physicians enjoy a "supply based demand" for their services. A patient will generally respond to their physician's advice to undergo investigation, referral or treatment, thereby potentially contributing to the overall incomes of physicians.

30. Further, as independent contractors, physicians begin billing the full price of a service as soon as they enter practice. The rate and fees for insured medical services do not differ based on the years of experience of the physician. This is unlike most employers who do not hire an employee at the top rate of pay, and instead use either a seniority based or performance based progression that could take a significant number of years before the employee reaches their top earning potential.

31. Government does not control the transfer of physicians to settings of greatest need. In an employment setting, if there is a requirement for work in another location, an employee may have a "Hobson's choice" between a transfer and a lay-off. Often there is no choice – a simple layoff and a new hire in the new location. It is a recognized management right to establish a work setting in another location

and employ employees at that location. Absent an individual physician's decision to work in an under-served area, the control rests with the physician. Even for under-served areas, for the vast majority of physicians, it is a choice to work in these environments.

32. Given the special contractual relationship enjoyed by physicians, they have the sole discretion to increase their overall compensation should they choose to do so. This also creates a fiscal problem for Government which cannot be remedied by the normal employment rules (e.g. set hours of work, layoff, transfer etc.) that can be applied in other settings. For all of the reasons noted, we respectfully submit that the determination of economic changes for Physicians must reflect the vast difference between the unique Physician Contractor Model and the Traditional Employment Model.

1.4 The Binding Arbitration Framework

33. Under the December 2012 Ontario Medical Association Representation Rights and Joint Negotiation and Dispute Resolution Agreement (the "OMA Representation Rights Agreement")(**Exhibit 3**), the Ministry of Health recognized the OMA as the exclusive bargaining agent of physicians. The BAF is an Appendix to the OMA Representation Rights Agreement agreed to by the parties and which became effective in June 2017. The BAF, among other things, sets out the process for mediation and binding interest arbitration to determine and decide outstanding issues respecting the content of Physician Services Agreements (the "PSA").

34. The scope of arbitration under the BAF focuses on economic and accountability issues, including (section 21 of the BAF):

    (i) Fees, payments and changes thereto by any part of government for the delivery of medical services to patients.

    (ii) The requirements or accountabilities for a physician to be paid for such a service.

    (iii) The components of the physician services budget (PSB), including the baseline PSB.

    (iv) Any changes to the PSB in any given year (i.e. any growth factor to be applied).

    (v) The determination of responsibility for and consequences of expenditures on physician services that exceed the permissible maximum PSB in a year.

    (vi) Payments for non-medical services related to certain physician benefits or EMR (if EMR is required).

35. The parties have agreed that the only issue for this Arbitration Board to decide is the price increase for Year 1 of this PSA (as outlined in the following section).

The Ontario government expenditures for physician services which are within the scope of arbitration under the BAF is called the Physician Services Budget (the "PSB"). The PSB expenditures can be divided into the following broad categories:

Fee-for-Service (FFS)	Physicians submit claims for payment for each service rendered based on the Schedule of Benefits (SOB).
Primary Care (PC)	Primary care physicians working in capitation model are paid based on terms set out in contractual agreements and may be non-FFS (salary, capitation) or a blend of FFS and non-FFS. Primary care physicians submit "shadow claims" based on the SOB to document services rendered to patients.
Alternative Payment Plans (APP) / Academic Health Science Centers (AHSC)	Group-based payments to specialist physicians based on terms set out in contractual agreements. Includes a variety of payment models.
On-Call programs	Payments to physicians for providing on-call coverage.
Other programs	Payments to physicians for other programs/initiatives including Underserviced Area Programs, locum programs, and fertility services.
Canadian Medical Protective Association (CMPA)	Payments to subsidize physicians for a portion of their fees to the CMPA.

36. In the 2022-23, expenditures in each PSB category were as follows:

PSB Category	**Payments ($M)**
Fee-for Service	10,334.3
Primary Care	2,622.5
Alternative Payment Plans (APP)	1,936.0
On-Call Programs	257.6
Other Programs	427.8
CMPA	165.8
Total	15,744.0

37. A detailed of summary of program-specific expenditures for 2022-23 is appended at **Exhibit 4**. At present, the Ministry is forecasting PSB expenditures will increase to $**16,985** billion in 2023-24.

1.5 The 2023 Implementation and Procedural Agreement for Year 3/Year 1

38. The 2021-24 PSA between the Ministry of Health and the Ontario Medical Association (OMA) contemplated a joint expenditure review for the 2023-2024 contract year (Year 3 of the PSA)(**Exhibit 5**). The expenditure review was intended to determine the final contract payment to physicians for that year.

39. The parties came to an agreement with respect to the Year 3 expenditure. We included at **Exhibit 6** the OMA and Ministry of Health 2021-24 PSA Year 3 Implementation and 2024-28 Procedural agreement (the "2023 Implementation and Procedural Agreement"). As per the parties agreement, the global increase for physicians for the 2023-24 year (i.e., Year 3) of the 2021-24 PSA was 2.8%.

40. Additionally, this agreement established a procedure by which the parties were able to conclude bargaining for Year 1 of the next PSA in a timely manner. The parties agreed to bifurcate the mediation/arbitration for the 2024-28 PSA into two procedural steps. The first step is mediation/arbitration of Year 1 of the PSA (2024/2025). Upon conclusion of Year 1, the parties have agreed to mediate/arbitrate Years 2, 3 and 4 of the PSA (2025/2026 to 2027/2028)

41. As such, this Board will address and determine the outstanding issue of the **price increase** for physicians for the period of April 1, 2024 to March 31, 2025. Specifically, The Ministry and the OMA have agreed that the Board will determine (excerpted below directly from paragraph 8 of the agreement):

> (a) The quantum, if any, of the additional price increase to be awarded, including in respect of years 1, 2 and 3 of the 2021-24 PSA, in Year 1 of the 2024-28 PSA, based on the factors set out in paragraph 5 above; and
>
> (b) Separate and apart from a) above, the quantum of the normative price increase to be awarded for Year 1 of the 2024-28 PSA.

To paraphrase the above:

a) Is any catch-up warranted pursuant to the last settlement?

b) What should the normative increase be for April 1 2024 to March 31, 2025.

42. In determining the price increase for Year 1, the parties have agreed:

> For the 2024-28 PSA, unless the parties agree to a different proportion, and subject to the Year 1 implementation provisions set out in paragraph 12 below, the total price increases in year 1 will be divided as follows:
>
> a. Seventy percent (70%) of the price increase awarded in Year 1 will be allocated to each section or physician grouping.
>
> b. The remaining thirty percent (30%) of the price increase will be allocated to permanent price increases in the form of targeted investments (e.g. Hospital On-Call Coverage (HOCC), pay for performance initiatives, family medicine initiatives, emergency medicine initiatives, APPs or AFPs, technical fees adjustments, gender pay gap initiatives, medical innovation and technology advances, patient complexity initiatives, fee schedule modernization, overhead expenses, locum/underserviced area/CME/skill optimization initiatives, retention initiatives, physician extenders, initiatives relating to the increased administrative burden on physicians, or benefit increases). The examples of targeted investments set out above are not an exhaustive list. For greater clarity, the inclusion of the list above is not determinative of either parties' support for such an initiative or in respect of either parties' position about the arbitrability of the initiatives.

1.6 Year 1 Price Increase (the "70/30" split)

43. As described above, the parties have agreed that the only issue for this Arbitration Board to decide is the price increase for Year 1 of this PSA. The parties have agreed that the price increase will be split between a "targeted" increase and price increases on the basis of a 70% fee increase (which will go through the targeted fee increase process described below) and a 30% targeted increase.

44. The Ministry is concerned that the OMA will argue that the 70% fee increase should be attributable to the basis for their economic adjustment proposal and the targeted increase should be attributable to their many special additional proposals beyond price adjustments. The Ministry disagrees completely.

45. Respectfully, the Board should decide what price increase is appropriate taking all factors into account and establish the overall percentage increase first. Then the split is automatic. This is the "top down", not "bottom up", analysis that the Ministry agreed to when entering into the 2023 Physician Services Agreement for Year 3/Year 1.

46. The history of bargaining favours entirely the "top down" approach to this matter. First, the prior voluntarily reached settlement (the 2021 PSA) provided that the Year 3 compensation increase would be first spent on targeted areas. The parties agreed that Hospital On Call Coverage ("HOCC") and the Alternative Payment Plans ("APPs") would be the first to receive available funding stemming from any increases. We provide below the excerpt from paragraph 8 of the 2021 PSA:

> 8. A prospective compounded adjustment to physician payments in the amount as determined pursuant to paragraph 6 (a) and (b) will be permanently allocated on the following basis:
>
> Step 1
>
> a) 1/5th of the year 3 increase, up to $75 million, will be added to the existing HOCC funding to fund the new burden-based Hospital On-Call Program, as described in paragraph 14 below, and in Appendix B;

> b) 1/10th of the year 3 increase, up to $50 million, will be allocated to fund Alternate Payment Programs, as described in paragraph 16 below, and in Appendix C.
>
> Step 2
>
> c) 1/4 of the year 3 increase, after the provisions made in a) and b), will be allocated to each section or physician grouping on an equal percentage amount; and
>
> d) 3/4 of the year 3 increase, after the provisions made in a) and b), will be allocated to each section or physician grouping, based on the hybrid CANDI-RAANI score, using updated fiscal 2022/23 data, and any methodological or other changes to the relativity tool as agreed by the parties.

47. As noted earlier, even the price increases in the previous settlement were split between general price increases and targeted fee increases. The settlement provided a 1% increase in Year 1, a 1% increase in Year 2, and a potential further increase in Year 3. The parties agreed that the increases from Year 1, 2 and potential Year 3 (after the targeted increases into HOCC and APP), that ¼ of the increases were allotted as general increases. The remaining ¾ of the increases were allocated to sections based on the RAANI-CANDI formula. The RAANI-CANDI formula allocates more funds to some physician sections and less to others. After that exercise the sections allocate their allotment enabling special adjustments to individual fee codes where the MOH and Section agree it is needed through a process called the Physician Payment Committee (PPC).

48. As a result of the 2021 agreement, the parties agreed to establish an ongoing PPC which replaced previous bilateral committees that reviewed and made recommendations on the implementation of price increases. The mandate of the PPC is, among others, to make recommendations on an annual basis to PSC regarding:

> Addition, revision and deletion of fee codes in the Schedule of Benefits based on the allocation to each section of the normative fee increases, having regard to such factors as time, intensity, complexity, risk, technical skills and communication skills required to

> provide each service, as well as flow-through and any other financial changes to non-fee for service contracts and to other programs…

49. Historically, there have been fees which, in the opinion of the OMA, were not deserving of a fee increase. In these instances, the fees have achieved no increases or increases below the general ATB for these fees. The funds which were not applied to these fees (the fees excluded from the ATBs) were instead redirected to enhance other fees at levels above the average ATB.

50. To further explain, we take the example of the Year 2 permanent increase of 2.01% under the 2021 PSA. The allotment to certain sections were as low as 0.52% and some allotments were above 2.01%, with the overall increase being 2.01%. Furthermore, within a section, the parties agreed to allocate the increases such that some fees/compensation items would receive NO increase, while other would receive an adjustment above that sections allotment.

51. The table on the following page illustrates the allotment to sections for the 2.01% permanent adjustment in physician payments in Years 1 and 2 of the 2021 PSA. This is based on the RAANI CANDI methodology for relativity as agreed to by the parties in the 2021 PSA:

Group	Description	April 1, 2023 (%)	ALLOCATION
23	Ophthalmology	0.5186%	$1,815,872
41	Gastroenterology	0.8916%	$1,531,711
33	Diagnostic Radiology	1.0826%	$8,681,280
1	Anaesthesiology	1.1899%	$6,267,541
9	Cardiac Surgery	1.2089%	$494,096
34	Radiation Oncology	1.2089%	$913,533
60	Cardiology	1.5257%	$6,181,942
44	Medical Oncology	1.5736%	$133,073
35	Urology	1.5982%	$2,105,090
28	Laboratory Medicine group	1.6231%	$1,060,798
16	Nephrology	1.7005%	$1,863,195
4	Neurosurgery	1.7271%	$758,583
6	Orthopaedic Surgery	1.7271%	$4,461,646
00_1	GP-1	1.7817%	$7,285,702
24	Otolaryngology	1.7817%	$2,022,491
15	Endocrinology	1.8383%	$1,654,452
62	Clinical Immunology	1.8673%	$322,970
8	Plastic Surgery	1.8967%	$1,567,368
2	Dermatology	2.0202%	$2,086,989
12	Emergency Medicine group	2.0524%	$4,088,273
5	Community Medicine	2.0742%	$11,966
11	Critical Care	2.0751%	$3,460,517
63	Nuclear Medicine	2.1187%	$434,021
17	Vascular Surgery	2.1527%	$811,451
48	Rheumatology	2.1527%	$1,533,306
3	General Surgery	2.1876%	$6,862,183
61	Haematology	2.3334%	$687,124
64	General Thoracic Surgery	2.3716%	$511,632
13	Internal and Occupational Medicine	2.4107%	$12,206,524
22	Genetics	2.4107%	$69,788
26	Paediatrics	2.4107%	$7,286,743
31	Physical Medicine & Rehabilitation	2.5753%	$1,468,001
47	Respiratory Disease	2.5753%	$2,583,650
00_2	GP-2	2.6186%	$26,484,033
7	Geriatrics	2.7081%	$811,861
20	Obstetrics & Gynaecology	2.7081%	$9,510,104

Group	Description	April 1, 2023 (%)	ALLOCATION
18	Neurology	2.8012%	$3,390,280
46	Infectious Disease	2.8012%	$920,385
19	Psychiatry	3.0540%	$15,271,787
00_3	GP-3	3.3385%	$25,979,543

52. The increases are then allotted to each section and split between the fees/compensation elements of the section. We provide below how the parties agreed to allocate the Year 1 and 2 permanent 2.01% increase for Primary Care fee codes:

Fee Code	Descriptor	2021 Fee Value	New Fee Value	Fee Increase	Percent Increase
A003	GP/FP - General assessment	$84.45	**$87.35**	$2.90	3.43%
C003	GP/FP - Non-emergency hospital in-patient services - General assessment	$84.45	**$87.35**	$2.90	3.43%
A005	GP/FP - Consultation	$84.45	**$87.90**	$3.45	4.09%
C005	GP/FP - Non-emergency hospital in-patient services - Consultation	$84.45	**$87.90**	$3.45	4.09%
W105	GP/FP - Non-emergency LTC in-patient Services - Consultation	$77.20	**$87.75**	$10.55	13.67%
A007	GP/FP - Intermediate assessment/well baby care	$36.85	**$37.95**	$1.10	2.99%
A917	GP/FP - Focused Practice Assessment (FPA)- Sport medicine FPA	$36.85	**$37.95**	$1.10	2.99%
A927	GP/FP - Focused Practice Assessment (FPA) - Allergy FPA	$36.85	**$37.95**	$1.10	2.99%
A937	GP/FP - Focused Practice Assessment (FPA) - Pain management FPA	$36.85	**$37.95**	$1.10	2.99%
A947	GP/FP - Focused Practice Assessment (FPA) - Sleep medicine FPA	$36.85	**$37.95**	$1.10	2.99%
A957	GP/FP - Focused Practice Assessment (FPA) - Addiction medicine FPA	$36.85	**$37.95**	$1.10	2.99%
A967	GP/FP - Care of the elderly FPA	$36.85	**$37.95**	$1.10	2.99%
A888	GP/FP - ED equivalent - Partial assessment	$36.85	**$37.95**	$1.10	2.99%
A777	GP/FP - Intermediate assessment - Pronouncement of death	$36.85	**$37.95**	$1.10	2.99%
C777	GP/FP - Non-emergency hospital in-patient services - Intermediate assessment - Pronouncement of death	$36.85	**$37.95**	$1.10	2.99%

Fee Code	Descriptor	2021 Fee Value	New Fee Value	Fee Increase	Percent Increase
W777	GP/FP - Non-emergency LTC in-patient Services - Admission assessment - Intermediate assessment - Pronouncement of death	$36.85	**$37.95**	$1.10	2.99%
A900	GP/FP - Complex house call assessment	$45.15	**$54.50**	$9.35	20.71%
A902	GP/FP - House call assessment - Pronouncement of death in the home	$45.15	**$54.50**	$9.35	20.71%
A905	GP/FP - Limited consultation	$72.10	**$73.25**	$1.15	1.60%
C905	GP/FP - Limited consultation	$72.10	**$74.25**	$2.15	2.98%
A911	GP/FP - Special family and general practice consultation	$144.75	**$150.70**	$5.95	4.11%
C911	GP/FP - Non-emergency hospital in-patient services - Special family and general practice consultation	$144.75	**$150.70**	$5.95	4.11%
W911	GP/FP - Non-emergency LTC in-patient Services - Special family and general practice consultation	$144.75	**$150.70**	$5.95	4.11%
A912	GP/FP - Comprehensive family and general practice consultation	$217.15	**$226.05**	$8.90	4.10%
C912	GP/FP - Non-emergency hospital in-patient services - Comprehensive family and general practice consultation	$217.15	**$226.05**	$8.90	4.10%
W912	GP/FP - Non-emergency LTC in-patient Services - Comprehensive family and general practice consultation	$217.15	**$226.05**	$8.90	4.10%
G010	Laboratory Medicine - Miscellaneous - one or more parts of above without microscopy	$2.14	**$2.64**	$0.50	23.36%
G365	Gynaecology - Papanicolaou Smear - Periodic	$8.65	**$12.00**	$3.35	38.73%
G420	Otolaryngology - Ear syringing and/or extensive curetting or debridement unilateral or bilateral	$11.35	**$13.15**	$1.80	15.86%
G538	Injections and Infusions - Immunization - Other immunizing agents not listed above	$4.95	**$5.80**	$0.85	17.17%
G590	Injections and Infusions - Immunization - Influenza agent	$4.95	**$5.65**	$0.70	14.14%
G841	Injections and Infusions - Immunization - Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP- IPV- Hib) - Paediatric	$5.40	**$6.35**	$0.95	17.59%
K017	GP/FP - Periodic health visit - Child	$43.60	**$45.25**	$1.65	3.78%
K131	GP/FP - Periodic health visit - Adult age 18 to 64 inclusive	$54.00	**$56.95**	$2.95	5.46%
K132	GP/FP - Periodic health visit - Adult 65 years of age and older	$77.20	**$80.95**	$3.75	4.86%
P003	Obstetrics - Prenatal care - General assessment (major prenatal visit)	$77.20	**$80.35**	$3.15	4.08%

Fee Code	Descriptor	2021 Fee Value	New Fee Value	Fee Increase	Percent Increase
P004	Obstetrics - Prenatal care - Minor prenatal assessment	$36.85	**$38.15**	$1.30	3.53%
P005	Obstetrics - Prenatal care - Antenatal Preventative Health Assessment	$45.15	**$47.70**	$2.55	5.65%

53. As can be seen from the above, the parties chose to increase some of the primary care fee codes as much as 38%, whereas approximately 200 other primary care fee codes received **zero** increases.

54. As can be established from the above, physician fee changes are unlike any traditional bargaining increase that are negotiated or awarded, where there is a general increase for all classifications and occasionally special adjustments for classifications that have fallen behind market. The determination of fee changes for physicians is virtually all special adjustments.

55. We also note that this method of allocation of increases is not unique to the last settlement. It has applied generally to physicians pre BAF and post BAF. Fee increases have traditionally been negotiated as “across the board” but have traditionally not been implemented “across the board” (ATB).

56. As an example, we excerpt below from *Ministry of Health and Long Term Care and Ontario Medical Association* award (unreported) for the April 1, 2017 to March 30, 2021 PSA (**Exhibit 7**):

> Except as specifically noted above, the distribution of the fee increases we have awarded is subject to relativity adjustments. The parties have agreed that in years one and two the PSA settled by this award that this distribution is governed by the terms of the parties’ interim relativity agreement. The board remains seized in respect of years three and four should the parties be unable to agree, and this matter can proceed in the next phase of these proceedings.

57. The Board should be aware the both the MOH and OMA have ideas and proposals for the targeted funds, none of which have been vetted through the crucible of

collective bargaining and mediation. In other words, some may have merit, some may not. However, and most importantly, the targeted investment will increase the income of physicians.

58. The concept of targeted funds is simply an extension of the allocation method for fees as set out above. The targets may not necessarily affect fee levels, but will more logically apply to design changes to models or targeted investments in physician compensation which are not at the fees level.

59. Targeted investments will increase the average physician income by the size of the target pot and in the same way that the average of the special adjustments are deemed price increases, so are the targeted monies price increases.

60. We submit that there is a long standing principle that an interest arbitrator must consider all compensation increases when dealing with the matter of the final disposition of the parties bargaining interest. This is as enumerated by Professor Weiler in depth in his 1981 interest arbitration award for SEIU and 46 Participating Hospitals[2], where he stated:

> I have always thought it essential not to look at any such item in isolation. With rare exceptions any such proposed improvement looks plausible on its face. The Union can point to some number of bargaining relationships where this point has already been conceded. It may even be true that, taken one by one, no single revision will actually cost that much. But, cumulatively, these changes can mount up substantially. Thus, sophisticated parties in free collective bargaining look upon their settlement as a total compensation package, in which all of the improvements are costed out and fitted within the global percentage increase which is deemed to be fair to the employees and sound for their employer that year.
>
> In fact, the general wage hike itself generates corresponding increases in the vast bulk of the compensation package represented by the wages, since it increases the regular hourly rate upon which holidays, vacations, overtime and other premiums depend. This means that in any one negotiating round only limited room is left

[2] *Service Employees International Union and Local Unions v. A Group of 46 Hospitals,* June 1, 1981 (**Brief of Authorities, Tab 1**)

> available for improvements in the scope and number of these contract revisions, and the Union must establish its own priorities among these various fringe items.
>
> These facts of free collective bargaining must be kept in mind if arbitration is, indeed, to try to replicate the results which would be achieved in the former setting. The reason is that the arbitration model does not inherently require the parties to make these tough choices in their negotiating positions. Inside the bargaining unit, for example, one group of employees may want higher pensions, another segment seeks longer vacations, a third is interested in a new dental plan, while others simply want as much higher take-home pay as possible (depending on their respective positions, ages, family situations, and so on). In the arbitration context, the Union does not have to worry that if it asks for too many things at once, the result will be a painful work stoppage. Indeed, the Union may be tempted -- as also the Employer which has its own diverse constituencies which it does not want to alienate -- to carry all of these initial demands forward to the arbitration hearing, on the theory that it has nothing to lose by asking. And perhaps, a party may even hope that the more improvement it does ask for, the more will be given.
>
> Certainly, it is essential to the integrity of arbitration that these latter assumptions not be reinforced.

61. Respectfully, the principle as detailed by professor Weiler supports the Ministry submission that the Board should decide what price increase is appropriate taking all factors into account and establish the overall percentage increase first. That overall percentage increase is the total compensation increase which will then be split 70%/30%.

1.7 The Ministry's Position

62. The Ministry respectfully submits that this Board ought to award a Year 1 compensation increase equal to 3% for the "normative" increase from April 1, 2024 to March 31, 2025. There is no need or basis for "catch up" for the previous freely negotiated and ratified settlement. This Ministry takes this position for the following reasons:

1. The last PSA was a freely negotiated and ratified settlement.

2. The average physician income adjustments compared favourably with other settlements where retention and recruitment is not a major concern. In order to make the comparisons to other settlements in the relevant time period, physician income is taken from the base year of 2019/2020 due to the impact of the COVID 19 pandemic.

3. We will illustrate that there is no concern of a diminished supply of physicians. Across Canada, Ontario has the best record in attracting medical graduates to train in Ontario. Further, Ontario has enjoyed a growth in physicians that far outstrips population growth. Evidence will show that Ontario is not losing physicians to other provinces.

4. Particularly with respect to primary care, the evidence on current compensation levels suggest Ontario is an attractive place to practice. While other provinces are catching up to Ontario, we will illustrate than on an objective review, the Ontario FHO model remains the most lucrative across Canada. The FHO provides a model of 6 or more physicians acting as a team to provide primary care services to their enrolled patients.

5. We will illustrate the wage trends for 2024 have been largely established (OPSEU, AMAPCEO, Teachers) in line with the Ministry's proposed compensation adjustment. There is no reason to deviate from these trends for physician compensation. The evidence to date shows that increased income for physicians will not translate into increased patient enrollment for

physician. There is also research which supports the findings of the Ministry of Health in this regard.

6. Wage trends for employees and other economic factors must be assessed against the growth in average physician income, not solely their price adjustments over time. We will illustrate that the level of compensation for physicians is significantly above the incomes of others.

7. It is recognized that physician compensation provides a gross payment for physicians and that expenses must be paid from these gross fees. We will illustrate that extraordinary increase to those expenses (if any) are appropriately addressed within the Ministry position.

63. The OMA may argue that Bill 124 restricted the negotiated result and the decision in this result should be treated as a Bill 124 Reopener. The only reopener agreements were Bill 124 reopeners brought about as a result of the successful overturning of this legislation. That legislation placed limits on the outcome of free collective bargaining.

That is not the case here.

1. Bill 124 did not apply to physicians.

2. There was no restriction or limits placed on bargaining outcomes in the last round of MOH/OMA bargaining as evidenced by the formula contemplated by Year 3.

3. The best evidence of how this legislation did not inform bargaining is the year 3 formula which, by the OMA's own admissions, anticipated a price increase of 2.1% to 3.6%.

4. Nothing in the parties memorandum of settlement references Bill 124 or incorporates it by reference. While the OMA may posit that it informed their bargaining and or their membership updates during ratification, that messaging was entirely of their own choice. How they chose to

communicate the deal the parties reached ought not be the basis upon which the OMA now seeks a Bill 124 reopener "me too" catch up or post agreement adjustment.

2. THE 2021 PHYSICIAN SERVICES AGREEMENT

2.1 Summary of Agreement

64. On February 10, 2022, the parties reached and subsequently ratified an agreement for a three year term from April 1, 2021 to March 31, 2024. The PSA included:

(i) A 1% lump sum one-time increase for Year 1 (2021-22)

(ii) A 2.01% lump sum one-time increase for Year 2 (2022-23) (reflecting 1% increase for 21/22 and a further 1% increase for 22/23 compounded)

(iii) In 2023-24 the 2.01% increase to physician compensation is made permanent. Payments are allocated through a new Physician Payment Committee, with ¼ paid to all sections and ¾ paid on a relativity basis using RAANI-CANDI.

(iv) Further, in Year 3 the parties agreed to a methodology for additional potential increases.

65. The methodology for further Year 3 compensation adjustments was based on the expenditure of the PSB. It is outlined in the agreement under Section A, “3. Year 3 Compensation Increases and Gain Sharing”. If the expenditure for the PSB in Year 3 was between $16.1759 Billion and $15.8587 Billion, the difference was allocated entirely to physicians as compensation adjustments. If the PSB expenditure was less than $15.8587, the difference between the actual PSB expenditure and $15.8587 was gainshared with government, with 75% of the difference being allocated to physician compensation adjustments. There was no financial liability for physicians if the PSB expenditure exceeded $16.1759 billion.

66. Further, the parties agreed to a methodology for the allocation of this further Year 3 compensation adjustment. The first 1/5th of the Year 3 increase, up to $75 million, was agreed to be added to the existing HOCC funding to fund the new

burden-based Hospital On-Call Program ("HOCC"). The next 1/10th of the Year 3 increase, up to $50 million, was agreed to be allocated to fund Alternate Payment Programs. After these monies were allocated, then 1/4 of the Year 3 increase was allocated to each section or physician grouping on an equal percentage amount and 3/4 allocated based on RAANI -CANDI relativity tool.

67. There was also additional funding provided to HOCC, certain APPs, Pregnancy and Parental Leave and the Physician Health Benefits Program. The parties also agreed on a comprehensive payment structure for virtual care.

68. The settlement was fully recommended and ratified by 72% of the voting membership. We will review the principles of Replication and retrospectively compare that settlement to the relevant post-Bill 124 trends later in this brief.

69. As submitted earlier, the parties subsequently came to an agreement on implementation of Year 3 of the agreement ("the 2023 PSA for Year 1/Year 3"). As per the parties agreement, the increase for physicians for the 2023-24 year (i.e. Year 3) of the 2021-24 PSA was 2.8%. Up to $40 million is made available out of the Year 3 increase to provide HOCC funding to new groups.

70. The Ministry also implemented/committed additional improvements outside the PSA during the term of the agreement totaling an estimated $35.2 million dollars (attached as **Exhibit 8**). Investments largely occurred in the creation or expansion of alternative funding plans (AFP's), i.e. additional opportunities for physicians to be compensated through alternative funding plans and not price increases.

3. AWARD FOR THE 2017 TO 2021 PHYSICIAN SERVICES AGREEMENT

3.1 The Arguments Presented at Arbitration

71. The parties referred the outstanding issues respecting the content of the PSA for the period of April 1, 2017 to March 30, 2021 to arbitration. We quote from the award the outstanding issues referred to the Board:

> 1. The OMA proposal for redress in respect of both across-the-board and targeted cuts to payments and programs beginning in 2015 and still continuing;
>
> 2. The OMA proposal for fee increases;
>
> 3. The OMA proposals for Academic Health Sciences Centres;
>
> 4. The OMA proposals for the Northern Ontario School of Medicine;
>
> 5. The OMA proposal for additional increases to and a process for reviewing technical fees;
>
> 6. The OMA proposal for redress resulting from changes to federal legislation governing physician incorporation;
>
> 7. The Ministry proposal for a hard cap on the Physician Services Budget;
>
> 8. The Ministry proposal for cuts to certain radiology, ophthalmology and cardiology fees; and
>
> 9. Proposals by both the OMA and the Ministry respecting the delivery of primary care particularly through Family Health Organizations (FHOs).

72. The paragraphs below demonstrate that to the extent catch up and overhead is an issue in this dispute in front of this Board, it can only be focused from 2021 forward. The OMA made extensive arguments regarding overhead, inflation and redress before the Board in the 2017 to 2021 PSA, and below are excerpts of a few of the relevant submissions made by the OMA in their 2018 Brief[3]:

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[3] Brief of the OMA re: Phase 1 – Overview, Redress and Nromative Compensation Increases.

29. The history of the 2015 cuts set out below entirely supports the OMA's position that these actions must be redressed; they were imposed unilaterally, in the absence of any meaningful bargaining process and independent dispute resolution process. By any measure, the unilateral across-the-board fee reductions were unjustified, unfair, and unduly punitive. The government's position that they should continue is also unprecedented in its audacity.

…

44. In sharp contrast to this early history, the period since 2012 has been marked by significant fee cuts and unilateral government actions including unilaterally imposed caps on the Physician Services Budget (overall expenditures on physician services), and unilateral across-the-board as well as targeted reductions to physician compensation. As set out below, these measures reduced the average billings per physician by over 6 per cent since from 2012/13 to 2015/16, while at the same time average physician costs of practice have increased by 8.1%, and inflation in Ontario by over 5%, in addition to the adverse effects on the public and the health care system. The negative impact, financial and otherwise, of these unilateral cuts continues to be felt by all doctors in Ontario.

…

100. In dollar terms, the impact of 2015 unilateral action can be summarized as 100.follows (see also detailed breakdown below in section D):

Item	Description	Impact ($million)	% Impact
2015 Jan UA	ATB (2.65% on all clinical payments excluding HOCC) and targeted cuts	-$451.4	-4.5%
2015 Oct UA	ATB (1.3% on FFS only) and targeted cuts	-$214.7	-2.1%
Total End Rate	Net 2015 UA and PSA	-$666.1	-6.5%

101. The OMA is seeking redress for these dramatic, significant and unjustifiable cuts 101.in this arbitration proceeding-- the restoration of this funding unilaterally removed from physician compensation.

…

109. It is also important to recognize that government payments to physicians are gross payments, from which the significant “overhead” costs of operating a medical practice-- including malpractice insurance premiums, salaries of employees, office space, equipment and medical supplies, administrative and other small business costs-- must be deducted to arrive at a physician’s net “take home” income. Accordingly, a physician’s net real income is defined as gross clinical income adjusted for overhead and inflation. As a result, at the same time as gross payments to physicians have declined, physician costs of practice continue to be subject to inflationary increases, so that the combined effect of a reduction in gross payments coupled with increases costs of practice magnifies the impact on the net take-home physician compensation.

…

166. The Ministry has expressed no intention of voluntarily ending its unilateral actions, or of restoring full payment to Ontario physicians. Clearly it has no intention of providing any redress whatsoever. In the result, it is left to this Board of Arbitration to order redress, at least for the period from April 1, 2017 (it being left to the Charter challenge to seek recovery for the period 2014 to 2017, when there was no fair and independent dispute resolution mechanism in place). And, with respect, there is no reason for this Board not doing so.

…

169. The OMA respectfully requests that this Board of Arbitration return the stolen money to physicians as of April 1, 2017, and redress the improper and unjustified unilateral government conduct, which was not justified at the time it was taken and which certainly cannot be justified under the 2017-21 PSA.

…

173. Accordingly, in addition to its proposal for redress, the OMA also proposes normative across-the-board increases to the OHIP fee schedule and to other payments, effective April 1, 2017, in respect of lost normative increases for the three-year period, 2014/15 – 2016/17, and going forward for the four-year period, 2017/18 to 2020/21.

…

195. The increasing costs of practice facing physicians can be seen in the graphs and data below. Staffing costs can be approximately 40-60% of physician overhead. Since 2000, however, staffing costs, as measured by the average weekly earnings of employees in the offices of Ontario physicians as reported by Statistics Canada, have increased by 118.26%. In contrast, over the same time period, inflation in Ontario, as measured by the Consumer Price Index, has only increased by 39%. In other words, while other expenses may have grown at the rate of inflation, staffing costs for physicians have gone up by three times the rate of inflation.

…

197. The same trend is apparent when total overhead costs are considered. Physician overhead has two main components: expenses related to salaries for staff (about 43.6% of total overhead) and other expenses such as rent (about 56.4% of total overhead). As set out in the table below, the salaries for staff grew by an average of 5.3% per year between 2004 to 2017. Over the same period, CPI grew at about 1.8% per year, which is a reasonable proxy for the rate of growth for non-staffing overhead expenses. Therefore, the total overhead growth over this time period is about 3.3% per year (i.e. it is the weighted average of the two overhead components: 0.436√ó0.053 + 0.564√ó0.018). This growth rate is about 1.5 percent higher than the Ontario CPI. In other words, if inflation is 2%, physician overhead expenses will increase by 3.5%.

…

202. When one takes into consideration not only overhead and declining clinical payments but also the impact of inflation, net real income for physicians in Ontario has declined by an incredible 20% since 2011/12. When seen in these terms, the need for redress for the 2015 cuts is both stark and compelling. This analysis is set out in the graphs below

…

203. In conclusion, overhead expenses for physicians in Ontario have grown and are likely to continue to grow at an annual rate that is even higher than inflation. The OMA's proposed normative increase of 2.6% in each of the four years commencing April 1, 2017, taking this key factor into account, redresses not only part of the impact of the last five years

(2012 to 2017) of unilateral cuts, but addresses this issue at least partly, on a go forward basis for the period 2017 to 2021. In contrast, the MOHLTC's proposal clearly gives no weight or consideration to this critical factor at all.

…

291. Furthermore, when compared to key economic indicators, such as CPI, IAI and GDP since the start of the cuts to physician compensation, the OMA proposals are reasonable and modest, and will allow Ontario physician compensation to at least partly keep pace with inflation and increasing costs of practice. In contrast, the MOHLTC's economic proposal, which only applies to specific groups, is so small that it does not even keep pace with inflation.

…

320. In contrast to the OMA proposal, which would allow fees and payments to physicians to at least keep pace with inflation, as measured by CPI Ontario, the MOHLTC's falls far short. Whereas inflation in Ontario since 2012 is forecasted to be at approximately 14.3% by 2020, seen in its most generous light, the MOHLTC proposal would only provide for 3% fee increases over the same time period, with that 3% only applying to some, not all, physicians, and largely if not entirely offset by proposed targeted cuts against certain specialities.

…

321. Furthermore, as discussed above, when Ontario physician overhead cost growth is added into the equation, overhead costs exceed inflation by an average of 1.5%. Thus, whether seen on their own, and even more so when compared to actual and predicted inflation and increasing costs of practice, the government's proposed fee adjustments are, in actuality, a cut to physician compensation.

…

324. In summary, the OMA submits that the government's normative proposal is woefully inadequate and falls far short of a fair and reasonable compensation increase. It ignores Ontario's strong economic position, **fails to provide any redress for the unilateral cuts for the 2012-2017 period, and does not keep pace with inflation, growing practice**

costs or normative wage increases negotiated or awarded to other groups.

73. On February 18, 2019, the arbitration board issued their award considering the submissions of both the OMA and the Ministry. The award is summarized below.

3.2 Summary of Award

74. Having regard to the respective parties submissions, including those noted above, the Arbitration Board awarded across the board increases and redress for the 2017/2018 to 2020/2021 PSA as follows:

(i) April 1, 2017 – a 0.75% compensation adjustment

(ii) April 1, 2018 - a 1.25% compensation adjustment

(iii) April 1, 2019 – a 1.0% compensation adjustment (0.5% of which was to remove the 2012 PSA payment discount, and as such not subject to a relativity distribution). A further 3.95% fee for service and 2.65% non-fee for service adjustment (removal of 2015 payment discounts and as such not subject to a relatively distribution).

(iv) April 1, 2020 – a 1.0% compensation adjustment

75. The Arbitration Board also awarded an increase to the innovation fund under the AHSC AFP (for a total $10 Million dollar increase) and the establishment of an Appropriateness Working Group (AWG) to identify and eliminate or restrict inappropriate or overused physician services or payments. The Arbitration Board further directed the establishment of a Multi-Stakeholder Primary Care Working Group and that parties continue discussions regarding technical fees.

4. THE BINDING ARBITRATION FRAMEWORK CRITERIA

4.1 Criteria Set Out in the BAF

76. As reviewed earlier, the BAF sets out the process for mediation and binding interest arbitration to determine and decide outstanding issues respecting the content of PSA. The following criteria are outlined in the BAF for the Arbitration Board to consider when rendering a decision:

> 25. In making a decision or award on any matters falling within the scope of arbitration, the arbitration board shall take into consideration the following factors and any other factors it considers relevant:
>
> (a) The achievement of a high quality, patient-centered sustainable publicly funded health care system;
>
> (b) The principle that compensation for physicians should be fair (in the context of such comparators and other factors that the arbitration board considers relevant) and reasonable;
>
> (c) such comparators as the arbitration board considers to be relevant, including but not limited to, physician compensation;
>
> (d) The economic situation in Ontario;
>
> (e) Economic indicators that the arbitration board considers relevant, including, but not limited to, the cost of physician practice;
>
> (f) Evidence-based relativity and appropriateness considerations; and
>
> (g) Data sources agreed to by the parties to be reliable, or otherwise the most reliable data available

77. We respectfully submit that all of the above criteria are relevant to the Year 3 issue of price except perhaps (f) which is not as relevant when the decision is solely based on price.

78. An overriding principle applicable to all interest arbitration is the Replication Principle which we will review in the following section. We will address the one issue before this Board but will not follow the sequence of the criteria in the Framework. Where a given subject is addressed we will reference the Framework Criteria that it falls within.

5. REPLICATION

5.1 The Replication Principle

79. **Arbitrators first look to the actions of the parties themselves as a key in determining their award.** The outcome of this arbitration should seek to replicate the results that would have been reached had the parties freely negotiated a settlement in a strike/lockout environment.

80. Professor Weiler clearly sets out the role of an interest arbitrator at page 27 of his 1981 award for *65 Participating Hospitals and CUPE*[4]:

> **[T]he arbitration model does not inherently require the parties to make these tough choices in their negotiating positions. .** . In the arbitration context, the Union does not have to worry that if it asks for too many things at once, the result will be a painful work stoppage. Indeed, the Union may be tempted as also the Employer which has its own diverse constituencies which it does not want to alienate to carry all of these initial demands forward to the arbitration hearing, on the theory that it has nothing to lose by asking. . . **Certainly it is essential to the integrity of arbitration that these latter assumptions not be reinforced**.
>
> *[Emphasis added]*

(a) Replication is Informed by the Parties Bargaining History

81. Outcomes that the Parties themselves have negotiated are strong evidence of what the Parties might have agreed had they freely negotiated a settlement. As such, in fashioning an award, the Board must consider that the parties previous pattern of settlements as the best evidence of what free collective bargaining would

---

[4] *65 Participating Hospitals and CUPE*, Re, 1981 CarswellOnt 3551 (**Brief of Authorities, Tab 2**).

have achieved. As the Chair of this Board stated in Ottawa (City) v Civic Institute of Professional Personal[5]:

> The job of a Board of Interest Arbitration is to do the best it can to replicate free collective bargaining: to come up with a settlement that the parties would have reached had collective bargaining followed its natural course and come to a conclusion with a collective agreement. **In doing so, Boards of Interest Arbitration are guided by many criteria, most notably replication: the replication, whenever possible, of free collective bargaining outcomes. One of the preferred methods of deciding interest disputes is to look at what the parties themselves have done: their previous pattern of settlements**.
>
> *[Emphasis added]*

(b) Replication Requires Arbitration to Reflect Labour Market Realities

82. In his November 1994 award for *Dana Manor & SEIU*[6], Arbitrator Samuels addresses the role of the interest arbitration board as follows:

> Fundamental Principle
>
> **Our task is to establish the terms which would have been agreed had the parties been able to resort to free collective bargaining.** By legislation, the parties have been prohibited from striking or locking-out, and therefore, if the parties are unable to agree on the terms of their collective agreement, the disputed matters must be decided by arbitration. Virtually all arbitrators have agreed that, in these circumstances, our central focus is to produce the terms which would have resulted from an unfettered bargaining process. **The purpose of the arbitration is to avoid a work stoppage in an essential industry, not to produce a collective agreement bereft of labour market realities**.
>
> *[Emphasis added]*

---

[5] *Ottawa (City) v Civic Institute of Professional Personnel*, 2022 CanLII 6819 (ON LA) [Ottawa] (**Brief of Authorities, Tab 3**).

[6] *Dana Manor and Service Employees International Union, Local 201*, November 2 1994 (**Brief of Authorities, Tab 4**).

83. In his 2012 SEIU Nursing Home Master award[7], Arbitrator Teplitsky states:

> The major monetary issue is the Union's demand for an across the board increase of 3% in each of the 3-year term of this agreement. The employer seeks a 0% increase in each year.
>
> I approach interest arbitrations principally form the following perspectives: It is wrong in principle for the public sector to subsidize the private sector. It is equally wrong for the private sector to subsidize the public sector.
>
> . . .
>
> Second, the driving force of interest arbitration is replication. All parties accepted this approach. Interest arbitrators should "replicate" the results of free collective bargaining. In so doing, expression is given to the principles I have expressed. Interest arbitration is a derivative process which should to the extent possible, depend on the results of settlements achieved in a right to strike/lockout regime.
>
> . . .
>
> It would be an odd result if interest arbitration produced substantially different results from freely negotiated private sector settlements in a comparable business.

(c) Replication Requires Demonstrated Need to Award Change: Arbitration is Not a Process of Splitting the Difference

84. The principle of "demonstrated need" flows directly from the application of the replication principle. Seasoned negotiators in a right to strike/lockout environment do not negotiate on the basis of abstract philosophical notions of social justice or on the basis of improving the collective agreement for improvement's sake. Negotiations are not an academic exercise, but an exercise grounded in pragmatism.

---

[7] *Participating Nursing Homes and Service Employees International Union Local 1 Canada*, September 27, 2012 (**Brief of Authorities, Tab 5**).

85. The principle of demonstrated need was well-described by Mr. R.L. Kennedy in the 1979 final offer selection between *Dufferin County Board of Education and OSSTF*[8]:

> An arbitrator or a final selector must set strict standards to be met before ruling that the clause be imposed upon the reluctant party. . . [The arbitrator or selector must] require that the party proposing the clause establish firstly that there is a demonstrated need for the provision desired and secondly that the proposed solution will in fact, deal with the need which is stated.

86. Replication is not a process of "splitting the difference". If it were, the best strategy for a party would be to file a long list of issues with extreme positions, hoping to achieve a compromise on some or all of them. The principle of demonstrated need and the folly of "splitting the difference" in interest arbitration is captured in a different way by Arbitrator Stanley.

87. In his award for *Ten Participating Nursing Homes and London and District Service Workers Union Local 220* (1987)[9], Arbitrator Stanley states:

> **Arbitration is a conservative process in the sense that it has a tendency toward maintenance of the 'Status Quo'. There must be a demonstrated need for change before we can address ourselves to the question of what change is acceptable. The Arbitration process should not be viewed as an opportunity to make changes in a collective agreement based on philosophical preferences**. In this way it should closely resemble the collective bargaining process which, in our experience, tends very quickly to focus on settling real practical problems and setting aside those proposals that stem from both parties simply seeking what would be, from their point of view, a better agreement.
>
> *[Emphasis added]*

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[8] *Dufferin County Board of Education and District 48 of the Ontario Secondary School Teachers' Federation*, March 19, 1979 (**Brief of Authorities, Tab 6).**

[9] *Ten London Area Nursing Homes and London and District Service Workers' Union Local 220*, May 19, 1987 (**Brief of Authorities, Tab 7**).

88. A similar view is expressed by Peter Barton in his 1982 award for the Participating Hospitals and London and District Service Workers' Union, Local 220[10]:

> It is quite clear that **interest arbitration is something more than throwing a number of issues at a Board and hoping that the Board will accept at least some of them.** We have not taken a position that because there are a lot of demands we must therefore necessarily grant a lot of them. **One of the considerations that has influenced us is whether or not there has been a proven need for a change**.
>
> *[Emphasis added]*

89. The Board should also note the words of Ontario Chief Justice Charles Dubin in his 1976 award under the *Metropolitan Toronto Boards of Education and Teachers Disputes Act*[11]. In that decision he writes that binding arbitration is most effective when the matters to be resolved are limited and when most of the contentious items in dispute have been agreed upon by the parties. At pages 7-8, Dubin goes on to say that:

> One of the difficulties in the arbitration process in the past has been the tendency of an Arbitrator to arrive at an Award which is a compromise of the respective positions of the parties. The effect of that has been to encourage the parties to keep all of the contentious items on the table and to discourage them from making a sincere effort to resolve items by themselves.
>
> . . .
>
> When an Arbitrator "splits the difference" he assumes the role of a Mediator rather than that of an Arbitrator. . .
>
> There may be cases in which the result arrived at by an Arbitrator properly results in an Award which falls between the respective positions of the parties. Such a result should only be arrived at when the evidence accepted by the Arbitrator supports such a finding. If

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[10] *Participating Hospitals and London and District Service Workers' Union Local 220*, January 18 1982 (**Brief of Authorities, Tab 8**).

[11] *Metropolitan Toronto Boards of Education*, March 3, 1976 (**Brief of Authorities, Tab 9**).

> such a result is arrived at for any other reason, the Arbitrator is not acting judicially.

(d) The Limitation of the Costs of Any Changes or Improvements is Inherent in the Application of the Replication Principle

90. It is helpful to refer to Professor Paul Weiler's June 1981 interest arbitration award for *SEIU and 46 Participating Hospitals*[12] for the purpose of understanding the conservative nature of the bargaining process and, by extension, the interest arbitration process.

91. We ask the Board to review the following informative comments:

> I have always thought it essential not to look at any such item in isolation. With rare exceptions any such proposed improvement looks plausible on its face. The Union can point to some number of bargaining relationships where this point has already been conceded. It may even be true that, taken one by one, no single revision will actually cost that much. But, cumulatively, these changes can mount up substantially. **Thus, sophisticated parties in free collective bargaining look upon their settlement as a total compensation package, in which all of the improvements are costed out and fitted within the global percentage increase which is deemed to be fair to the employees and sound for their employer that year**.
>
> *[Emphasis added]*

(e) Replication vs. Social Justice

92. When engaged in the exercise of determining what the parties would have freely negotiated, outstanding matters are not to be decided upon on the basis of an arbitrator's view of "fairness" or "social justice".

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[12] *Service Employees International Union and Local Unions v. A Group of 46 Hospitals,* June 1, 1981 (unreported) (**Brief of Authorities, Tab 1**)

93. On this issue, Arbitrator Dorsey states in an award for *Board of School Trustees, School District No. 1 (Fernie) and Fernie District Teachers' Association*[13]:

> The task of an interest arbitrator is to simulate or attempt to replicate what might have been agreed to by the parties in a free collective bargaining environment where there may be the threat to resort to a work stoppage in an effort to obtain demands: This consensus accepts that **an arbitrator's notions of social justice or fairness are not to be substituted for labour market and economic realities**.
>
> *[Emphasis added]*

94. The same principle is reflected in Arbitrator Paula Knopf's award for *Pembroke v. Pembroke Professional Fire Fighters' Association*[14] wherein she states:

> First and foremost, as a board of arbitration resolving an interest dispute, the task is to try to replicate collective bargaining as closely as possible. . . **The task of an interest board of arbitration is not to impose terms and conditions that seem attractive or even fair to the board of arbitration.** Instead, the task of a board of arbitration is to design a collective agreement that comes as close as possible to what the parties could have expected to achieve if they had been forced to impasse. *[Emphasis added]*

95. Arbitrator Teplitsky also succinctly reinforces this theme in his August 1982 decision for *SEIU and the 46 Participating Hospitals*[15]:

> Interest arbitrators interpret the collective bargaining scene. They do not sit in judgment of its results.

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[13] *Re Board of School Trustees, School District No. 1 (Fernie) and Fernie District Teachers' Association,* 1982 CanLII 5072 (BC LA), <https://canlii.ca/t/jmlj2> (**Brief of Authorities, Tab 10**)

[14] *Pembroke v. Pembroke Professional Fire Fighers' Association*, [2000] O.L.A.A. No. 612 (**Brief of Authorities, Tab 11**)

[15] *A Group of 46 Hospitals and Service Employees International Union, A.F. of L., C.I.O., C.L.C., Locals 183, 204, 268, 478, 532 and 777*, August 31, 1982 (**Brief of Authorities, Tab 12**).

96. The objective is not to determine “right” or “wrong,” “fair” or “unfair,” or to reach a decision that reinforces a matter of social justice that an arbitrator prefers.

(f) The Free Collective Bargaining Principle as it Applies to Interest Arbitration

97. Many arbitrators have reviewed the applicability of replicating free collective bargaining to interest arbitration. We reference the comments of three arbitrators who have long and extensive experience in interest arbitration.

98. Arbitrator Teplitsky writes the following at pages 4 and 5 of his August 1982 decision for *46 Participating Hospitals and SEIU*[16]:

> [T]he goal of compulsory binding arbitration is to ensure that the parties affected by the loss of the right to strike fare as well, although not better than, those parties whose settlements are negotiated within the context of the right to strike.

99. Also of relevance are the comments of Arbitrator Teplitsky in a January 1986 decision *in Extendicare, Bestview, Diversicare and ONA*[17]. At pages 10 and 11 he states:

> When parties bargain, they seek to achieve certain goals. The arguments they make to support or oppose particular claims are, in reality, nothing more than arguments. 'Parity' is such an argument. **As I have said, the goal of bargaining is to make a mutually acceptable bargain. It is not to win an argument.**
>
> *[Emphasis added]*

100. If interest arbitration is to work, it must replicate what the actions of the parties might have been had the parties been able to negotiate outside the framework of

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[16] *A Group of 46 Hospitals and Service Employees International Union, A.F. of L., C.I.O., C.L.C., Locals 183, 204, 268, 478, 532 and 777*, August 31, 1982 (**Brief of Authorities, Tab 12**).

[17] *Extendicare, Bestview Health Care and Diversicare and Ontario Nurses Association*, January 15, 1986 (**Brief of Authorities, Tab 13**).

interest arbitration. Again, with respect, the best evidence is found in the actions of the parties themselves.

6. RETENTION AND RECRUITMENT

6.1 A Significant Factor in Recent Health Care Awards

102. We respectfully submit that the Retention and Recruitment issue that was present in the recent hospital awards are not present here. In the recent award in the *Participating Hospitals and ONA (unreported award dated April 25, 2023)*[18], the Chair of this Board determined the terms and conditions for Registered Nurses and Nurse Practitioners at 127 Participating Hospitals in Ontario. In this case, the issue of nursing supply and nursing vacancies was front and center. In determining their award, the Board considered the employer's ability to attract and retain employees and awarded their compensation increase in recognition of the evidence that there was a nursing recruitment and retention crisis in Ontario's hospitals. We excerpt the relevant portions of the award below:

> Under HLDAA, a Board of Interest Arbitration is to consider the employer's ability to attract and retain employees. **The evidence presented establishes that there is truly a nursing recruitment and retention crisis in Ontario's hospitals**: Practical Solutions – an OHA report – is unequivocal about this. That is why it recommended "robust retention strategies," and "immediate funding to bolster staffing models." Practical Solutions corroborates ONA's submissions: ONA members are leaving their jobs because vacancies were not being filled, creating unmanageable workloads leading to burnout and exhaustion driving employees from the workplace. The evidence referred to in this award unambiguously establishes that there are historic numbers of vacancies, which generally take a very long time to fill, and the suggestion that this can mostly be explained by employees moving intra-hospitals is not generally supported in the evidence. Increased capacity with staffing not yet catching up is only a small part of the explanation.
>
> Hospitals are using agency nurses because they are compelled to do so. Hospitals are offering inducements, outside the collective agreement, because that is the only way in which they can meet their staffing needs: that is also the only explanation for the incredible expansion in overtime, and for hiring agency nurses at double or triple the collective agreement rates; because compensation is a, if

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[18] *Participating Hospitals and ONA*, July 20, 2023 (**Brief of Authorities, Tab 14**).

> not the, key driver in attracting employees. The Participating Hospitals repeatedly acknowledged in their brief that "there is currently a significant gap between hospital capacity and nursing supply."
>
> Among the best means to recruit and retain, and to incentivize individuals to enter a profession, is compensation. We simply cannot conclude that the other incentives to retain and presumably motivate staff – described above – will be successful in retaining (and motivating) nurses given the demonstrated shortages, as documented in the OHA's Practical Solutions and elsewhere.
>
> …Wage increases can reasonably be expected to keep people in the workforce, incentivize people who have left to return (including RNs who have let their registration lapse together with the almost two thousand RNs the College of Nurses records as not currently employed), and attract future employees. We have borne in mind that the Participating Hospitals, as they acknowledge in their brief, are competing for nurses "within a competitive labour market."
>
> We have, therefore, replicated free collective bargaining by awarding general wage increases of 3.5% in 2023 and 3% in 2024 and have also made adjustments – given recruitment and retention – to the grid building upon the second ONA reopener. The award takes inflation into account and is an acknowledgement of the incontrovertible evidence that for more than a decade inflation has greatly outpaced RN rates (and that current inflation was inadequately considered in the two recent ONA reopeners and needed, in any event, to be reflected in this award as it continues to significantly erode spending power). We have also increased premiums for Mentorship, Student Supervision and Team Leader as each of these functions is critical to the professional development of new nurses. We have, however, made no adjustments to any of the shift premiums as they are already best in class.

103. We will describe and provide in the following submission that the circumstances for physicians are entirely different than the evidence provided for Hospital Nurses above. We will show that:

(i) Ontario has no problem attracting medical students.

(ii) Ontario has enjoyed a growth in physicians that far outstrips population growth; and

(iii) Physicians are an integral part of the health care system but they are part of a holistic team of primary care providers including Nurse Practitioners and Pharmacists, to name a few. All of these skilled providers will continue to be utilized to support and care for Ontario's patients.

6.2 Positive Supply and Retention of Ontario Physicians

104. We will describe and provide data below to demonstrate that the recruitment and retention of physicians is not an issue that comparatively warrants the type of interest arbitration response that occurred with respect to Ontario's nurses in the RN award.

(a) Applications to Medical School

105. Many, many individuals want to become physicians. This is first seen in the applications to Medical School. Unlike most other university programs, a four year medical degree is largely pursued by those who wish to become a physician. While the formal requirement for entry to Ontario medical schools is a bachelor's degree, it rare for students accepted to medical schools to have only one degree. It is common for students entering medical school to have multiple completed university degrees and/or master's degrees.

106. In the chart below, it is clear that there are a significant number of people applying to medical school; it is not hard to attract individuals towards medical school. In other words, there is no shortage educated individuals wishing to become physicians.

Medical School Applicant-Placement Analysis

School[19]	2022 MD Applications	2022 Class Size	Applicant to Placement Ratio
McMaster	5,228	205	**25.5**
University of Ottawa	4,962	183	**27.1**
University of Toronto	4,302	293	**14.7**
Western	2,415	171	**14.1**
Queens	5,131	139	**36.9**
NOSM	1,710	74	**23.1**

107. There is a significant ratio of applicant to available placements in Ontario's medical schools. At least 14 of 15 applicants are denied their request. Using the University of McMaster as an example, for every 25 applicants, only one will be offered a placement.

[19] McMaster: https://ischoolconnect.com/blog/mcmaster-university-all-you-need-to-know-about-the-acceptance-rates/#:~:text=McMaster%20University%20%7C%20Acceptance%20rate%20for%20medical%20school,-Inspiring%20change%20and&text=With%205%2C228%20applications%20for%20the,acceptance%20rate%20of%20only%203.9%25.
Uni. Of Ottawa: https://www.uottawa.ca/faculty-medicine/undergraduate/admissions
Uni. Of Toronto: https://applymd.utoronto.ca/admission-stats, https://applymd.utoronto.ca/domestic-applicants#:~:text=The%20University%20of%20Toronto%20welcomes,Medicine%20and%20Integrated%20Health%20seats%20.
Western: https://www.schulich.uwo.ca/med_dent_admissions/docs/AdmissionStatistics_Medicine_Classof2022.pdf
Queens: https://meds.queensu.ca/academics/undergraduate/admissions/admissions-statistics
NOSM: https://www.nosm.ca/nosm-university-admissions-learner-recruitment/ume-program-md-degree-admissions/class-profiles/

(b) Province of Choice for Residency

108. Once a medical student graduates, they apply across Canada for Residency placements. We provide the table below showing for the 2023 residency placements the percentage of graduates from most provinces matched to residence province.

% of graduates matched to residency		**Resulting Residency Province**							
		NS	**PQ**	**ON**	**MB**	**SK**	**AB**	**BC**	**NF**
Province of Graduation	**NS**	**53.92%**	1.96%	29.41%	0.98%	1.96%	6.86%	1.96%	2.94%
	PQ	0.82%	**90.32%**	6.30%	0.12%	0.12%	0.93%	1.17%	0.23%
	ON	3.30%	1.76%	**78.68%**	1.10%	1.65%	4.62%	7.80%	1.10%
	MB	1.98%	0.00%	10.89%	**72.28%**	0.00%	9.90%	2.97%	1.98%
	SK	4.17%	0.00%	20.83%	6.25%	**38.54%**	14.58%	15.63%	0.00%
	AB	2.01%	1.00%	12.71%	4.35%	3.68%	**66.56%**	9.03%	0.67%
	BC	4.07%	0.74%	16.30%	0.74%	2.22%	12.22%	**62.59%**	1.11%
	NF	16.46%	2.53%	13.92%	1.27%	2.53%	2.53%	2.53%	**58.23%**

109. The ability for Ontario to attract their own graduates is 78.68%. In other words, 78.68% of individuals trained in Ontario choose Ontario in a high enough ranking to be placed in Ontario. Ontario's attractiveness far exceeds the comparable statistics for other provinces except Quebec. Respectfully the higher percentage in Quebec is based on language. Individuals who attend medical school in Quebec and are from Quebec want to stay in Quebec due language and cultural preferences.

110. The table also demonstrates that with the exception of Newfoundland, Ontario is an attractive destination for those who graduate in other provinces. We are almost everyone's ranked second choice behind their home graduating province. It is even true for Nova Scotia, with almost 30% of graduates being placed in Ontario.

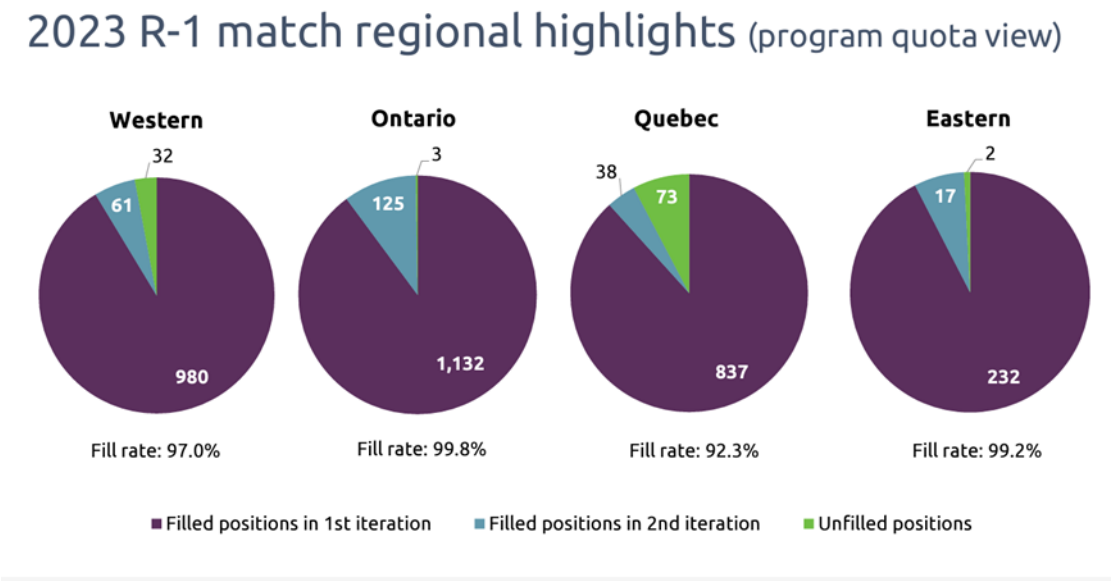
We provide a table below summarizing Ontario's placement rates for all other provinces:

% of graduates matched to residency		Resulting Residency Province	
		Ontario	**Ontario Ranking**
Province of Graduation	**NS**	29.41%	2
	PQ	6.30%	2
	MB	10.89%	2
	SK	20.83%	2
	AB	12.71%	2
	BC	16.30%	2
	NF	13.92%	3

(c) Canadian Resident Matching Service (CaRMS)

111. A further compelling statistic which shows Ontario's superior ability to recruit residents is seen in their ability to fill their placements. The Canadian Resident Matching Service (CaRMS) is a national, independent, not-for-profit, fee-for-service organization that provides a fair, objective and transparent application and matching service for medical training throughout Canada.

112. The 2023 CARMs data[20] showed the following:



113. Based on this data, in the 2023 CaRMS match, Ontario had the best overall fill rate at 99.8% for residents in Canada. Note that the three unfilled positions noted above were for the federal Department of National Defense.

114. The 2024 CaRMS match is now under consideration. Ontario offered 76 more residency positions through the 2024 match than in 2023, offering a total of 1,324 positions. In spite of this increase, Ontario filled all but one of its positions, which is a provincial first. Ontario filled 100% of the family medicine residencies (547) and 99.9% of the specialty positions (775 out of 776 positions). This was an extremely positive match year for Ontario.

(d) The Number of General Practice (GP)/Family Practice (FP) Physicians have Increased

115. As noted in the introduction, the Government has every intention over the long term to train more family medicine physicians and thereby continue to increase the

[20] CARMs Data: https://www.carms.ca/data-reports/r1-data-reports/

number of family doctors. The evidence refutes any OMA claim that physician growth in family practice has deteriorated. The evidence shows that Ontario successfully retains family physicians, as the number of family physicians has continued to increase year over year. The number of family physicians in Ontario increased by 14.2% from 14,449 physicians in 2016/17 to 16,505 physicians projected in 2023/24. This exceeds population growth over this period, which was 13.4%. The table below displays the growth in physician supply during this period.

Fiscal Year	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24 (Proj.)	Growth 2016 to 2023 (#)	Growth 2016 to 2023 (%)
GP Supply (Headcount)	14,449	14,772	15,110	15,392	15,541	16,134	16,265	16,505	2,056	14.2%

(e) The Proportion of New General Practice (GP)/Family Practice (FP) Residents Entering Family Practice has remained consistent

116. In 2022, a total of 1,093 physicians completed their residency in Ontario. Of these, 443 (40.5%) were for family practice (FP) and general practice (GP).

117. Since 2018, the proportion of new GP/FP residents entering family practice has remained consistent at 41%. On the page that follows is table with the breakdown of the primary care model's that new graduate GP/FP physician become affiliated with by fiscal year:

Primary Care Funding Models	**Total Number of Physicians**				
	FY 2018/2019	FY 2019/2020	FY 2020/2021	FY 2021/2022	FY 2022/2023
Family Health Organization (FHO)	**246 (58.71%)**	**232 (58.44%)**	**224 (64.0%)**	**250 (55.19%)**	**246 (55.53%)**
Fee For Service (FFS)	106 (25.30%)	104 (26.2%)	78 (22.29%)	154 (34.00%)	138 (31.15%)
Rural Northern Physician Group Agreement (RNPGA)	21 (5.01%)	15 (3.78%)	21 (6.00%)	24 (5.30%)	28 (6.32%)
Family Health Network (FHN)	24 (5.73%)	18 (4.53%)	20 (5.71%)	23 (5.08%)	25 (5.64%)
Family Health Group (FHG)	38 (9.07%)	43 (10.83%)	30 (8.57%)	24 (5.30%)	19 (4.29%)
Sioux Lookout Area (SLA)	17 (4.06%)	8 (2.02%)	11 (3.14%)	7 (1.55%)	11 (2.48%)
Blended Salary Funding Model (BSM)	6 (1.43%)	3 (0.76%)	2 (0.57%)	5 (1.10%)	8 (1.81%)
Other Funding Models	4 (0.96%)	10 (2.52%)	1 (0.29%)	4 (0.88%)	8 (1.81%)
Weeneebayko Health Authority (WAHA)	8 (1.91%)	7 (1.76%)	3 (0.86%)	3 (0.66%)	7 (1.58%)
Comprehensive Care Funding Model (CCM)	3 (0.72%)	2 (0.50%)	1 (0.29%)	3 (0.66%)	1 (0.23%)
Total # of new graduates (GP/FP residents)[21]	**419**	**397**	**350**	**453**	**443**
Total # of new graduates all physicians[22]	**989**	**949**	**723**	**1,184**	**1,093**

118. The data set out above also demonstrates that the funding model of choice for new graduates is the Family Health Organization (FHO) model.

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21 Data on physicians' graduation is collected under the Ontario Physician Reporting Centre (OPRC) which is a collaborative project of four organizations: the Ontario Ministry of Health, the College of Physicians and Surgeons of Ontario (CPSO), the Council of Ontario Faculties of Medicine, and the Ontario Medical Association.

22 Note that the sum of the category may be greater than the total, as physicians may have multiple affiliations throughout the year. Physicians who complete their residency outside of Ontario and came back to the province right after are not included in these results.

7. THE ECONOMY & CURRENT ENVIRONMENT OF COMPENSATION

7.1 The State of the Ontario Economy

(a) Government's Fiscal Plan

119. The Government of Ontario is taking a responsible approach to its finances so Ontario can have a strong fiscal foundation now and in the future. The economic strategy is predicated on controlled and strategic spending as Ontario continues to face uncertainty due to ongoing geopolitical instability, high interest rates and inflation.

120. The 2024 Budget (**Exhibit 9**) estimates show that the government is projecting a deficit of $3.0 billion for 2023-24. Over the medium term, the government projects deficits of $9.8 billion in 2024–25, and $4.6 billion in 2025-26 before planning for a surplus of $0.5 billion in 2026–27[23]. While Ontario is on a path to balance the budget, it must continue to invest responsibly to build a strong province. Elevated uncertainty still remains about the future pace of economic growth, which may impact these projections further, and which underscores the need for the government to take a responsible, targeted approach to spending.

121. Managing Transformation: A Modernization Action Plan for Ontario, September 21, 2018 (the "Line-by-Line Review", **Exhibit 10**), identifies labour as the single largest expenditure across the OPS and broader public sector ("BPS"). At the time, $71 billion was spent annually on labour[24]. A 1% increase in compensation meant an additional $710 million in annual expenditures.

122. The Bank of Canada in their February 27, 2023 report, *Firms' inflation expectations and price-setting behaviour* (**Exhibit 11**) stated that tightening monetary policy slows price growth by reducing overall demand, slowing cost increases and raising

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[23] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 4 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).
[24] Line-by-Line Review, at p. 27 (Brief of Exhibits, Tab 10).

competitive pressure on firms. High inflation expectations may encourage large price increases if firms believe that cost growth will remain high after a tightening of monetary policy. High inflation and elevated inflation expectations could cause a wage-price spiral, anchoring high inflation with harmful economic consequences.

123. A wage-price spiral occurs when workers expect inflation to continue rising so workers demand, and achieve, wage increases to keep up with rising prices. Rising wages result in firms raising the prices of goods and services. At the same time, workers have more disposable income to increase demand for goods and services. This creates an inflationary loop. The government, as a key contributor to wage-setting across the province, must carefully consider the impact of wage increases on the overall economy.

(b) Economy-Based Interest Arbitration Considerations

124. The 2024 Budget shows that for 2023–24, the government is projecting a deficit of $3.0 billion. Over the medium term, the government is projecting deficits of $9.8 billion in 2024–25 and $4.6 billion in 2025–26, before reaching a surplus of $0.5 billion in 2026–27[25].

125. Ontario's real gross domestic product ("GDP") expanded by 3.9 per cent in 2022, down from 5.4 per cent growth in 2021. High interest rates are expected to continue negatively impacting Ontario's economy in 2024, with real gross domestic product (GDP) growth projected to slow from an estimated 1.2 per cent in 2023 to 0.3 per cent in 2024. Real GDP growth is projected to accelerate to 1.9 per cent in 2025, and 2.2 per cent in 2026 and 2027[26].

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[25] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 143 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).
[26] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 5 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).

(c) The Economic Situation in Ontario

126. The economic environment, including the financial obligations and challenges facing the province, informs the interest arbitration decision.

(i) Debt and Borrowing

127. An important consideration for every board of arbitration is whether monetary improvements sought by employees are fair and reasonable given the prevailing economic conditions and overall state of provincial finances.

128. Government services and investments have corresponding costs to taxpayers. To pay for programs and services, the province collects taxes and other revenues, and receives transfers from the Federal government. When the province runs a deficit, it is spending more than it collects and effectively it must borrow to make up the difference. Borrowing creates an obligation that has to be repaid in the future, which allows for lower taxes and sustained services today at the expense of lower services and/or higher taxes in the future.

129. Ontario's ability to manage its debt is in part, a function of the province's GDP. An important indicator related to the province's fiscal position is the net debt-to-GDP ratio, which is the measurement of debt as a percentage of GDP. The 2024 Budget shows that Ontario's net debt-to-GDP ratio is now forecast to be 38.0 per cent in 2023–24, compared with the forecast of 37.8 per cent in the 2023 Budget and 38.4 per cent in the 2023 Ontario Economic Outlook and Fiscal Review; while Ontario's net debt-to-revenue is now forecast to be 203 per cent in 2023–24, compared with the forecast of 199 per cent in the 2023 Budget[27]. As the debt increases dramatically relative to the level of GDP, the ability to manage and repay becomes more and more difficult.

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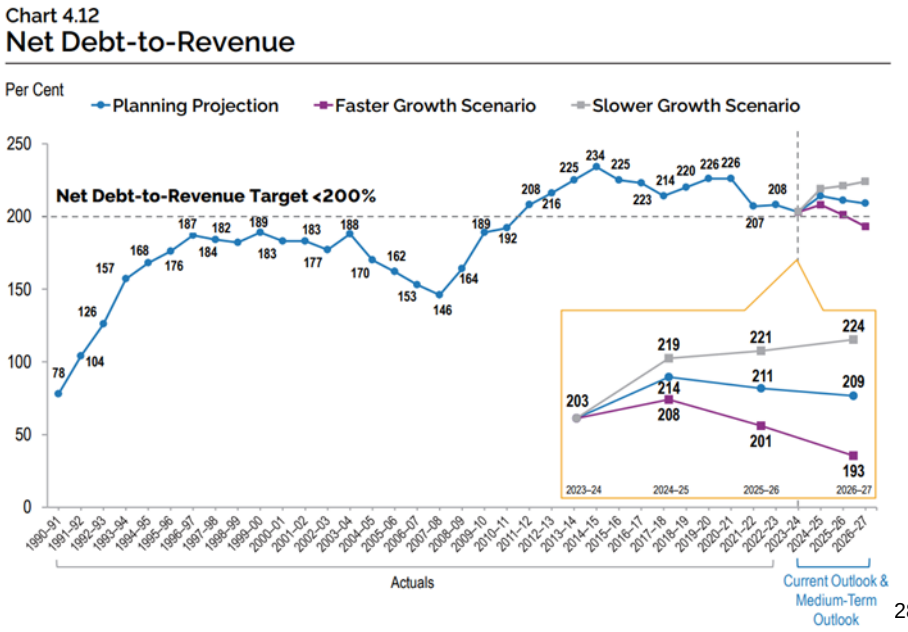
[27] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 13 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).



[28]

130. As Ontario continues a path to balance the budget, the borrowing program remains responsibly and prudently managed to minimize interest on debt ("IOD") costs. Ontario paid $12.4 billion in interest costs in 2022–23 and is forecast to pay $12.8 billion in interest costs in 2023–24, $13.9 billion in 2024–2529 and $14.7 billion in 2025–26.[30]

131. A one percent change in interest rates either up or down from the current interest rate forecast is estimated to have a corresponding change in Ontario's borrowing costs of approximately $700 million in the first full year.[31] If the size of the borrowing program remains unchanged from the current projection. The current interest rate environment poses a risk to the government given the large IOD costs, as such it is essential that the government spends responsibly, especially in advance of a period of economic uncertainty and rising interest rates.

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[28] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 191 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).

[29] 2023 Fall Economic Statement (FES), 2023 Ontario Economic Outlook and Fiscal Review — Building a Strong Ontario Together, Background Papers, p. 143

[30] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 8 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).

[31] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 185 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).

132. The Province's debt and interest on debt over the past ten years is illustrated below. Ontario remains a highly indebted jurisdiction, with its debt increasing from $276.2 billion in 2013-14 to $400 billion in 2022-23 and projected to increase to $414.8 billion in 2023-24.[32]

Net Debt and Interest-on-Debt

	Fiscal Years 2013–14 to 2026–27 ($ Millions)													
	Actuals										Current Outlook	Medium–Term Outlook		
	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24	2024–25	2025–26	2026–27
Net Debt	276,169	294,557	306,357	314,077	323,068	337,623	352,382	372,501	382,842	400,484	414,814	439,056	459,767	474,477
Net-Debt-to-GDP	39.7%	40.5%	40.3%	39.7%	39.2%	39.3%	39.5%	42.6%	39.9%	38.2%	38.0%	39.2%	39.5%	39.1%
Net-Debt-to-Revenue	224.6%	233.5%	225.0%	223.2%	214.4%	219.5%	225.6%	225.8%	206.8%	207.6%	203.0%	213.5%	211.4%	209.4%
Interest-on-Debt (IOD)	11,155	11,221	11,589	11,727	11,912	12,385	12,497	12,296	12,583	12,389	12,843	13,913	14,716	15,232
IOD-to-Revenue	9.1%	8.9%	8.5%	8.3%	7.9%	8.1%	8.0%	7.5%	6.8%	6.4%	6.3%	6.8%	6.8%	6.7%

Source: Ontario Financing Authority.

133. The government made a strong commitment in the 2024 Budget regarding its debt reduction strategy. Net debt-to-GDP for 2023–24 is projected to be 38.0 per cent. Over the medium term, the net debt-to-GDP ratio is forecast to be 39.2 per cent in 2024–25 and 39.5 per cent in 2025–26.[33] This ratio measures the relationship between a government's obligations and its ability to meet them, indicating the burden of government debt as a share of the economy.

134. Meeting the provincial 2024 Budget targets would reduce the debt burden, improve the provincial credit rating, and achieve a reduced cost of borrowing all while making a substantial commitment to primary care, hospital care and key components of population health.

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[32] Ontario Financing Authority, "Province's Debt History (https://www.ofina.on.ca/borrowing_debt/debt.htm) accessed 14th February 2024

[33] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 190 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).

(ii) *The Province's Program Expenses*

135. With economic challenges and elevated uncertainty, the government is has previously and is continuing to invest in various initiatives, with significant year over year increases in the health sector. Overall, The province spent $186.4 billion on programs in fiscal 2022-23. In 2023–24, program expense is projected to increase to $194.5 billion. Over the medium-term outlook, program expense is projected to increase every year, growing to $200.6 billion for 2024-25, $205.8 billion by 2025-26, and to $208.9 billion by 2026-27.[34]

(iii) *Budget Risks and Sensitivities*

136. The outlook for inflation remains a key source of uncertainty for the global economy as well as for Canada and Ontario. Although several major central banks, including the Bank of Canada and the U.S. Federal Reserve, have signalled that they have likely concluded their recent cycles of interest rate increases, a significant downside risk is that they may maintain higher interest rates for longer if they judge it necessary to ensure the return of inflation to the target rate.

137. Conversely, an upside risk for the economy is that inflation normalizes more rapidly than expected, allowing for a quicker easing of monetary policy. Economic growth in the United States has proven surprisingly resilient in the face of significant monetary policy tightening, including strong consumer demand and buoyant labour markets. Continued economic resilience in the United States represents an upside risk to the Ontario economy, notably for growth in Ontario exports. However, the economy in the United States is exposed to significant risks as the cumulative impact of past interest rate rises are expected to weigh on aggregate demand. There is also a risk of fiscal consolidation, as ongoing sizable fiscal deficits have raised federal government debt in the United States to high levels.

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[34] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 8 [2024 Ontario Budget] (Brief of Exhibits, Tab 9)

138. In 2024 Budget there are Faster Growth and Slower Growth scenarios that the economy could take over the next few years[35]. These alternative scenarios should not be considered the best case or the worst case, but reasonable possible outcomes in this period of uncertainty.

Table 2.8

Ontario Real GDP Growth Scenarios

(Per Cent)

	2024p	2025p	2026p	2027p
Faster Growth Scenario	1.4	2.6	2.5	2.5
Planning Projection	**0.3**	**1.9**	**2.2**	**2.2**
Slower Growth Scenario	(0.6)	1.4	2.1	2.1

p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024, and alternative scenarios.
Source: Ontario Ministry of Finance.

Table 2.9

Ontario Nominal GDP Growth Scenarios

(Per Cent)

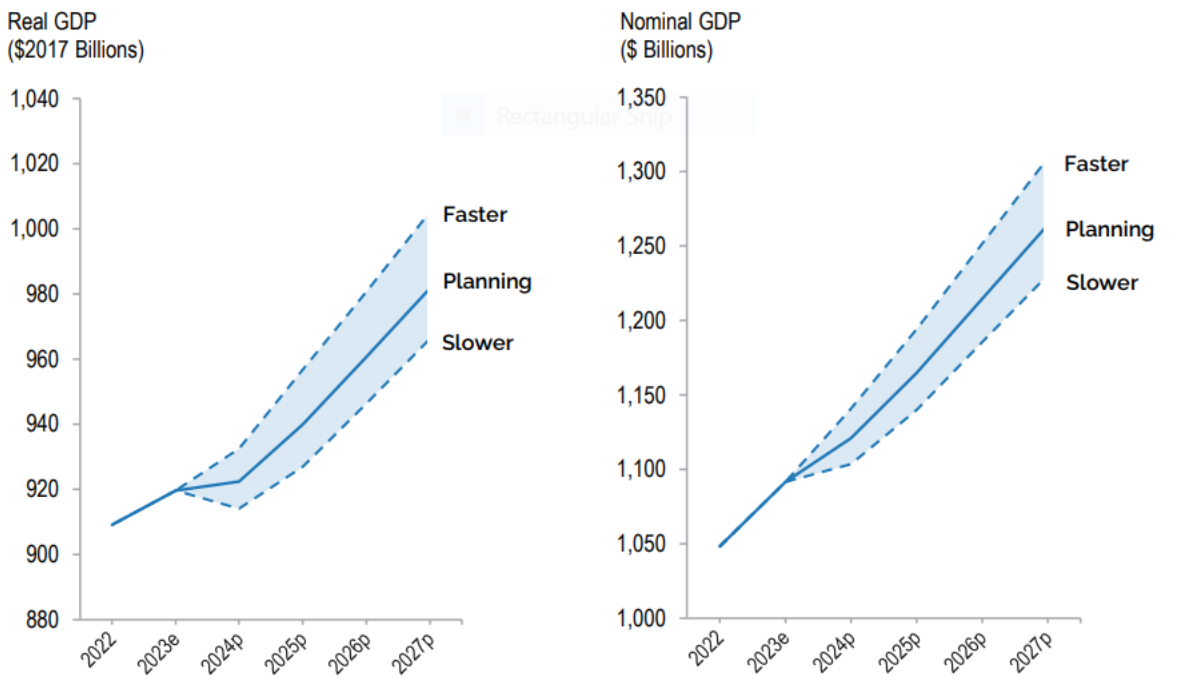
	2024p	2025p	2026p	2027p
Faster Growth Scenario	4.5	4.7	4.8	4.6
Planning Projection	**2.7**	**3.9**	**4.3**	**4.1**
Slower Growth Scenario	1.1	3.3	4.0	3.8

p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024, and alternative scenarios.
Source: Ontario Ministry of Finance.

139. By 2027, the cumulative level of real GDP growth in the Faster Growth scenario is 2.4 per cent higher than in the Planning Projection, while in the Slower Growth scenario, the level of real GDP is 1.6 per cent lower. The nominal GDP scenarios show a wider range of outcomes over the next several years compared to the real GDP scenarios, due largely to heightened near-term uncertainty around GDP inflation. By 2027, the cumulative level of nominal GDP growth in the Faster Growth scenario is 3.5 per cent higher than in the Planning Projection, while in the Slower Growth scenario, the level of nominal GDP is 2.7 per cent lower.

[35] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 137 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).

Chart 2.15
Range of Ontario GDP Scenario Forecasts



e = estimate.
p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024 and alternative scenarios.
Sources: Statistics Canada and Ontario Ministry of Finance.

36

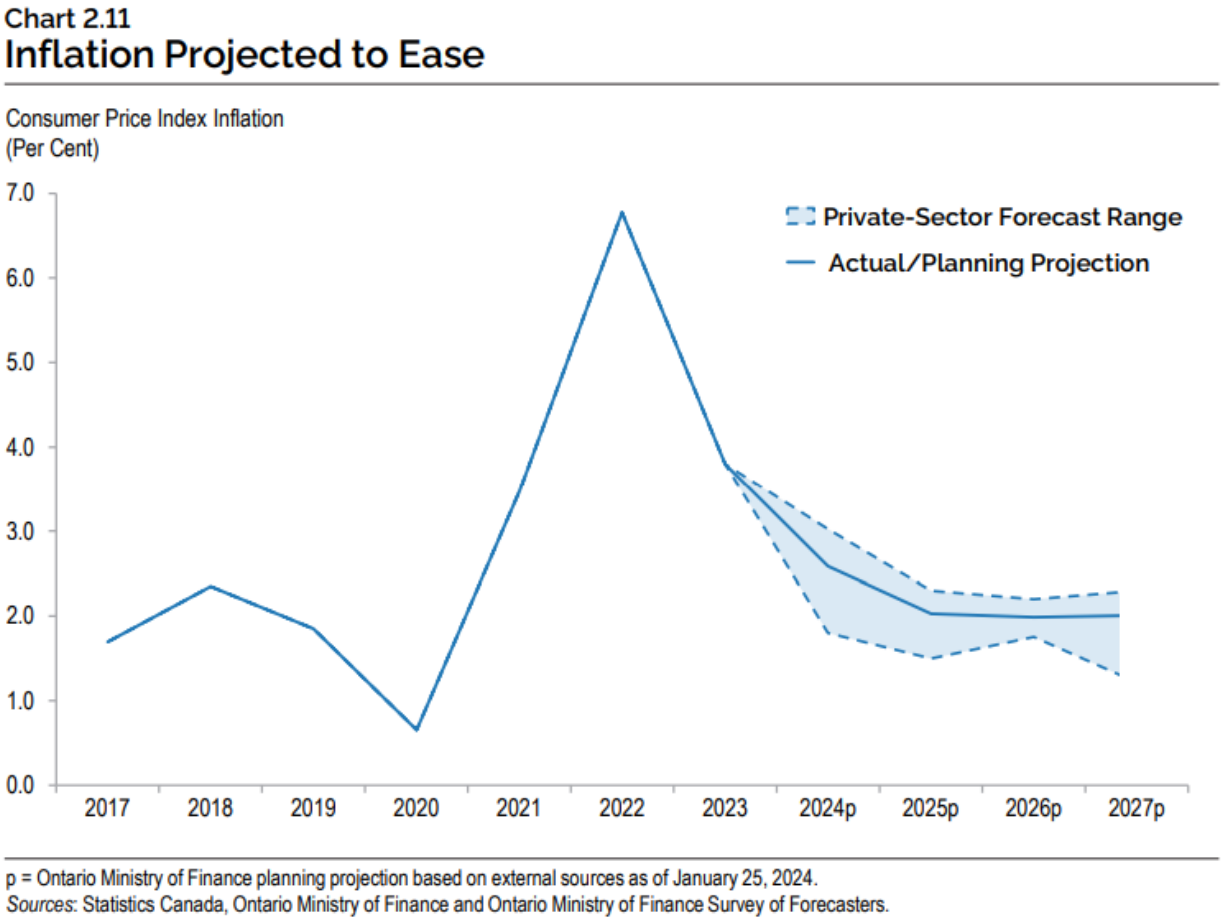
(iv) Conclusion

140. The government's economic strategy is predicated on controlled and strategic spending as the province continues to face uncertainty as a result of ongoing geopolitical instability, high interest rates and inflation. We note that government has received a clean audit opinion from the Province's Auditor General for six years in a row. The government continues to take a balanced approach to managing compensation to ensure public services continue to remain affordable and to invest responsibly to build a strong province.

[36] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 138 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).

7.2 Inflation Expectations for 2024

141. The Ontario Budget states that the expectations for 2024 inflation is 2.6%. We excerpt the following chart from the 2024 Budget which outlines the Ontario Ministry of Finance planning projection for inflation[37]:



142. The estimate in the chart for inflation is not a Government derived statistic. The Ontario Ministry of Finance regularly consults with private-sector economists while tracking their forecasts to inform the government's planning assumptions. The number derived is the average of the private-sector economists.

[37] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 132 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).

143. Further, three external economic experts reviewed the Ontario Ministry of Finance's economic planning assumptions and found them to be reasonable.

144. Further, for March 2024 the Statistics Canada 12 month CPI for Ontario was 2.6%[38], modestly higher than the previous February 2024 of 2.4%.

145. When the typical utilization increase to average physician compensation is added to the Government position for a 3% price increase (based on settlement trends), physician income will significantly exceed inflation in 2024.

146. Inflation has never been a benchmark for physician income, and there is no pattern to indicate that physician income tracks inflation in each year, 2024 will certainly be a year where the rate of inflation will be lower than the rate of increase in physician income.

[38] https://www150.statcan.gc.ca/n1/daily-quotidien/240416/t002a-eng.htm

7.3 Comment on Productivity (GDP/Employment)

147. Productivity is a measure of how efficient a jurisdiction is at producing something relative to the resources being utilized. Being able to grow the economy by producing higher-value goods and services or by using less labour or energy, for example, would make a jurisdiction more productive overall. It will in turn generate or free up assets that can be reallocated elsewhere.

148. Below is a quote from an article by RBC economists titled "Weak productivity is threatening Canada's post-pandemic wage growth" published February 28, 2024[39] which explains productivity and its repercussions:

> Worker productivity (output per hour worked) is inextricably linked to worker pay over time, and Canadian productivity estimates have been among the more worrying statistics in the post-pandemic economy after already underperforming for decades before.
>
> When productivity rises, it means that more output is generated with the same number of hours worked. That boosts profit for businesses but also creates room for wage growth without lowering businesses' bottom lines. Productivity normally increases over time as businesses innovate, buy new equipment, and workforce skills improve.
>
> In the long run, productivity growth is the main driver of improvement in living standards. It's essentially the only way that business profits and worker wages can sustainably rise at the same time. But, there is little reason to think that productivity growth will substantially accelerate in the near term. Capital investment has remained relatively weak. Productivity growth coming from the service sector—typically less dependent on new machinery and more on human capital (i.e. skills and education)— has also lagged.

149. Overall, Canada's declining labour productivity has received attention and worry in recent months. Excerpted below are relevant and recent comments from Bank

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[39] https://thoughtleadership.rbc.com/weak-productivity-is-threatening-canadas-post-pandemic-wage-growth/#:~:text=Canadian%20wage%20growth%20has%20been,are%20threatening%20future%20wage%20gains.

of Canada senior deputy director Carolyn Rogers stating that the country faces a productivity “emergency”[40].

> Canada must tackle weak productivity to inoculate the economy against factors that will drive future inflation, such as the pullback from globalization, said Carolyn Rogers, senior deputy governor of the Bank of Canada.
>
> “An economy with low productivity can grow only so quickly before inflation sets in. But an economy with strong productivity can have faster growth, more jobs and higher wages with less risk of inflation,” she said in a March 26 speech in Halifax, adding that other drivers of inflation will include changing demographics, the economic impact of climate change and global tensions.
>
> “While U.S. spending continues to increase, Canadian investment levels are lower than they were a decade ago,” Rogers told her audience, adding that Canada has also fallen behind most of its G7 peers, with only Italy seeing a larger decline in productivity relative to the United States.
>
> “You’ve seen those signs that say: In emergency, break glass — Well, it’s time to break the glass,” she said.

[40] Barbara Sheter, Bank of Canada says the country faces a productivity ‘emergency”, Financial Post, Mar. 26, 2024, at https://financialpost.com/news/economy/bank-of-canada-says-nation-faces-productivity-emergency

8. THE ISSUE OF CATCH UP (BAF CRITERIA – SECTION 25(B))

8.1 The Distinction Between Price and Income

150. The distinction between Price and Income has been a consistent debate since government started to pay for physician's billings for their services to patients. The fundamental question is whether the contractor's price per unit or total income (revenue) is the appropriate measure [when determining how to compare the wage increase that a nurse (or other health care provider or public servant) received in any given year compared to a physician].

151. Here is one side to the debate. The OMA may say that price alone is the appropriate measure. The OMA may state that if a physician earns more than what price alone would dictate, that physician has worked harder and the incremental income related to their increased activity should not be counted as income for purposes of comparison or analysis inside this interest arbitration.

152. We note that the physicians' contractual arrangement is a business model. Businesses generally succeed by decreasing price and finding efficiencies while increasing overall revenue including both price and increased activity.

153. We will illustrate that physicians' increased income is not the result of physicians increasing their services delivered to the patients of Ontario. We will review the relevant data (this is available to both parties) that demonstrates that, overall, physicians have decreased the number of patient visits and the number of unique patients seen.

154. We further submit that a comparison to others' income levels and consideration of others' historical increases should and must be on the basis of average income (i.e. revenue per physician). Herein, we have provided the Board with data and analyses that illustrate that the OMA arguments about increasing the delivery of services resulting in the increased revenue leads to an illogical conclusion.

8.2 Historical Average Compensation Increases are Greater than Price

155. As already submitted, fee increases have traditionally been negotiated as “across the board” but have traditionally not been implemented as “across the board”. Historically, there have been fees which, in the opinion of the OMA, were not deserving of a fee increase. In these instances, a sophisticated and knowledgeable OMA has argued for and successfully achieved no increases or increases below the general ATB for various fee codes.

156. The funds which were not applied to these fees (the fees excluded from the ATBs) were instead redirected to enhance other fee codes (again, for the purposes of this argument we are agnostic as to the reasons) at levels above the average ATB.

157. Although it may seem on the surface to be counterintuitive, history has shown us that the incomes for physicians whose fees have been frozen or minimally adjusted actually rise more quickly than the incomes for physicians who have received extra fee increases.

158. It is not that physicians who receive extraordinary increases do not benefit from those increases. In fact, they do. However, it is because the specialties where fees have been frozen or minimally adjusted have been able to generate sufficient volume increases and efficiencies to generate significant income improvements without needing a fee increase. **The net result is that incomes overall are, in fact, higher than the published price increase.**

159. By using this reasonably sophisticated technique and in stark contrast to the employee who receives a general wage increase to their salary grid, the OMA has been able to squeeze greater true income increases out of price increases than would appear possible on the surface. Taken over a period of many years, the technique adds significant net improvements over what were perceived to be the average increase. An analysis of the historical data provides evidence for this phenomenon.

160. To be clear, the Ministry does not submit that this is bad faith on the part of the OMA, simply sophisticated bargaining. However, these facts inform and should be factored into the calculation and consideration of any awarded price increase and serve to contrast the benefit of a "price increase" to physicians compared to a general wage increase to a nurse, for example.

161. The chart below shows the 10 specialities which had the highest average percentage growth in billings. As can be seen, the specialities of Ophthalmology, Diagnostic Radiology, and Cardiology have seen minimal increases in their fees since 2000/2001. Despite this, they have seen extraordinary growth in their average billings during the same period of time (2000/01 to 2022/23).

Specialty	Fee Rate Growth	Growth In Avg. Billings	% Growth in Avg. Billings	% Growth in Avg. Billings above Fee Rate Growth	% of Income from FFS
Ophthalmology	16%	$ 443,557	130%	**114%**	93%
Diagnostic Radiology	9%	$ 401,809	124%	**115%**	95%
Cardiology	19%	$ 285,704	85%	**66%**	92%
Gastroenterology	24%	$ 267,948	75%	**51%**	92%
Neurosurgery	27%	$ 259,375	98%	**71%**	70%
Anaesthesia	35%	$ 220,471	103%	**68%**	83%
General Surgery	33%	$ 157,411	61%	**28%**	87%
Orthopaedic Surgery	27%	$ 157,089	60%	**33%**	86%
Urology	29%	$ 150,302	51%	**22%**	88%
Physical Medicine	68%	$ 138,611	91%	**23%**	90%

Source: MOHLTC claims data 2000/01 to 2022/23

162. The Ministry submits that even though there have been general “across the board” fee increases, certain physician specialities have, in fact, received greater fee increases than the across the board fee increases. This is because other physician specialities have received little or no fee increases since 2001. At first glance, this would seem to be a simple trade-off, analogous to a trade-off in collective bargaining. However, in collective bargaining, the trade-offs which reflect a savings capture **permanent** savings.

163. The trade-offs noted herein did not result in any savings to offset the above average fee increases. In fact, the specialities which received little or no fee increases ended up enjoying some of the highest income increases of all groups.

164. Therefore, in reviewing the need for a fee increase for 2024/2025, this Board should be aware of this “trade-off effect” which is a unique advantage to physicians and not available to other groups of employees who bargaining collectively. Historically, certain physician specialities have received higher fee increases than the “published” increases. Those specialities receiving lower fee increases than the “published” price increases were still able to increase their income. In fact, their income increases outstripped their colleagues who received the higher fee increases. There in no reason to expect that this “trade-off effect” will not continue and we ask the Board to take that fact into account in its deliberations.

8.3 The Average Compensation Increase for Physicians in the Last PSA

165. The parties reached a freely negotiated settlement last round that was well ratified by the voting membership. Both sides were represented by skilled negotiators and had the assistance of a highly skilled mediator. The Replication principle credits great significance to the actions of the parties and generally accords it some weight.

166. That notwithstanding, we compare the increases in Average Physician compensation to AMAPCEO and OPSEU prior settlements and subsequent Bill 124 Reopener awards, tracking the same years to reflect the actions and results of those parties following the high inflation periods.

167. As described in the previous section, the physician incomes have historically increased greater than the negotiated or awarded “across the board” fee increases.

168. The last PSA was for the period of April 1, 2021 to March 31, 2024. During this period, the physician incomes increased greater than the negotiated “across the board” fee increases. Using the average expenditure per physician as an equivalent to physician income, physicians have received a greater increase than the negotiated price increases. However, given the anomalies of physician income from April 2020 to March 2021 stemming from the pandemic, we have used the base year of April 2019 to March 2020. Over this time period, physician incomes were higher than the awarded/negotiated price adjustments:

Fiscal Year	Income per Physician
2019-20	**$ 426,382**
2023-24 (F)	**$ 469,144**
% Awarded/Negotiated Price Adjustments from 2019-2020 to 2023-24	**5.8%**[41]
% Increase in income per physician from 2019-2020 to 2023-24	**10.0%**

169. As the above clearly notes, physician income over this time period has exceeded those Ontario public sector settlements and awards that we expect the OMA to rely upon in their effort to compare wage increases with fee increases in order to advance a "catch-up" award beyond the terms of the parties' freely negotiated settlement. We take a closer look at these public sector outcomes below.

[41] April 1, 2020 – 1% (awarded under previous PSA), April 1, 2021 – 1%, April 1, 2022 – 1%, April 1, 2023 – 2.8%

8.4 The Normative Increase for April 1, 2023 to March 31, 2025

171. In this section, we posit that the Year 1 wage increase of 3% proposed by the MOH is fair, reasonable and realistic within the context of trends in the other OPS bargaining units and the broader public sector. Again, using the average expenditure per physician as an equivalent to physician income, the average physician over this time period exceeded significant Ontario public sector settlements and awards.

172. The table on the following page contains the major public sector outcomes which were negotiated or awarded recently and therefore capture today's economic climate.

Date of Award/MOS	Award or MOS	Parties	Term	ATB Increases
6/2/2017	Extension Agreement[42]	Government & OPSEU Unified	4 years 1/1/2018-12/31/2021	Jul 2017 – 1.5% Jan 2019 - 1% July 2019 - 1% Jan 2020 – 1% July 2020 – 1% Jan 2021 – 1% July 2021 – 1%
6/13/2017	Extension Agreement [43]	Government & AMAPCEO	4 years	Oct 2017 – 1.5% Apr 2019 - 1% Oct 2019 - 1% Apr 2020 – 1% Oct 2020 – 1% Apr 2021 – 1% Oct 2021 – 1%
8/25/2023 2/9/2024	Remedy MOS plus Kaplan Award[44]	Government & OSSTF	2 years 9/1/2019 – 8/31/2021	Yr. 1 – 1.75% Yr. 2 – 1.75% Yr. 3 – 3.75%
9/21/2023 2/9/2024	Remedy MOS plus Kaplan Award	Government & ETFO Education Workers	2 years 9/1/2019 – 8/31/2021	Yr. 1 – 1.75% Yr. 2 – 1.75% Yr. 3 – 3.75%
11/16/2023 2/9/2024	Remedy MOS plus Kaplan Award	Government & ETFO Teachers	2 years 9/1/2019 – 8/31/2021	Yr. 1 – 1.75% Yr. 2 – 1.75% Yr. 3 – 3.75%
1/21/2024	Lee Reopener Award[45]	Government & OPSEU Unified	3 years 1/1/2022 – 12/31/2024	Yr. 1 – 3% Yr. 2 – 3.5% Yr. 3 – 3%
1/26/2024	Lee Reopener Award[46]	Government & AMAPCEO	3 years 4/1/2022 – 3/31/2025	Yr. 1 – 3% Yr. 2 – 3.5% Yr. 3 – 3%

[42] Extension agreement for Government & OPSEU Unified contained at Exhibit 19

[43] Extension agreement for Government & AMAPCEO contained at Exhibit 20

[44] *The Crown and OSSTF and ETF*O, February 9, 2024 contained at Exhibit 21

[45] Lee Reopener award for OPSEU contained at Exhibit 22

[46] Lee Reopener award for AMAPCEO contained at Exhibit 23

173. Between June 5, 2019, when Bill 124 was introduced, and November 29, 2022, when it was overturned by the Ontario Superior Court, all Public Sector bargaining units were subject to the three-year moderation period with salary increases and total compensation limited to 1% in each year.

174. Since November 2022, the major OPS bargaining units and major broader public sector Education bargaining units have had reopener awards released. We note that the increases listed in the reopener awards summarized above are inclusive of the previously negotiated 1% increases in each year of the moderation period.

175. Given the anomalies of physician income from April 2020 to March 2021 stemming from the pandemic, we have used the base year of April 2019 to March 2020. We compared the total wage increases in major public sector bargaining units to physician compensation increases in the table on the following page.

Wage Increases for Major Public Sector Unions vs Physician Avg. Increases:

DATE	OPSEU	AMAPCEO	TEACHERS	PHYSICIANS (Avg)
Jan. 1/20	1%			10.0% as per para 169
Apr. 1/20		1%		
Jul. 1/20	1%			
Sep. 1/20			1.75%	
Oct. 1/20		1%		
Jan. 1/21	1%			
Apr. 1/21		1%		
Jul. 1/21	1%			
Sep. 1/21			3.75%	
Oct. 1/21		1%		
Jan. 1/22	3%			
Apr. 1/22		3%		
Jul. 1/22				
Sep. 1/22			TBD	
Jan. 1/23	3.5%			
Apr. 1/23		3.5%		
Jul. 1/23				
Sep. 1/23			TBD	
Jan. 1/24	3%			
Apr. 1/24		3%		3%** (minimum 4% if historical utilization added)
Jul. 1/24				
Sep. 1/24			TBD	
TOTAL*	13.50%	13.50%	5.5%	13% (minimum 14% if historical utilization added)
# of Years	5	5	2	5
Avg./Year	2.7%	2.7%	2.75%	2.6% (minimum 2.8 if historical utilization added)

**We note that the totals are not compounded

**Ministry Position (plus minimum 1% utilization if historical utilization added)

8.5 Current Comparisons Outside Healthcare

176. It is the general arbitral view that employees in higher salary categories should not always expect the same percentage level of increase as their lower paid counterparts.

177. We quote arbitrator Teplitsky in his 1978 award of *43 Participating Hospitals and SEIU*[47], on the subject of relative increases for employees earning disparate salaries. Mr. Teplitsky was referencing the highly-regarded 1976 award of Justice Dubin in the *Metropolitan Toronto Secondary School Teachers'* dispute when he stated the following:

> Employees whose incomes are relatively modest are most affected by the impact of increases in the cost of living. Mr. Justice Dubin accepted the validity of this observation in the Metropolitan Toronto Secondary School Teachers dispute, Award dated March 3, 1976 at page 45 where he stated:
>
> By applying the percentage increase in the CPI against the salary, those in the higher salary brackets receive more than those in the lower salary brackets. In my opinion, it is an inaccurate reflection of the cost of living to apply it in this way. The impact of the increased cost of living is felt most by those who earn less.
>
> (emphasis mine)
>
> In a period when compensation increases lag behind cost of living increases, one should avoid becoming mesmerized by percentage increases. These percentage increases should be translated into the actual dollars generated. Accordingly, settlements even in the same industry are less weighty as comparables if the employees affected by those settlements earn substantially higher than the employees covered by this collective agreement.

178. Physicians are the highest paid of other major professional groups in the province. We have chosen Ontario's Ontario Public Servants as represented by OPSEU and

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[47] *Service Employees International Union Locals 183, 204, 268, 478, 532, 777 and A Group of 43 Hospitals*, June 19, 1978 (**Brief of Authorities, Tab 15**).

AMAPCEO for the following analysis. The table below sets out the Average OPS Bargaining Unit Salaries for 2023 compared to Ontario Physicians. This labour relations context is particularly relevant in these proceedings.

OPS Bargaining Unit Salaries for 2023[48]

	Avg. Annual Salary	**Physicians Ahead**	**Annual Impact of 3%**	**Value of $14,074**
PHYSICIANS	**$469,144**		$14,074	
AMAPCEO	$100,862	365%	$3,025	14%
OPSEU Corrections	$78,487	498%	$2,355	17.9%
OPSEU Unified	$73,034	542%	$2,191	19.3%

179. The table above illustrates that:

(i) An average physician gross payments are between 365% and 542% higher than the average salaries of employees in these other government bargaining units.

(ii) A 3% increase for the average physician is worth at least $11,049 more than the same increase for another OPS unionized employee.

(iii) The value of a 3% increase for the average physician would represent an increase of between 14% and almost 20% for an OPS employee in AMAPCEO, OPSEU Corrections or OPSEU Unified.

[48] Data reflects averages of actual salaries in 2023, adjusted to incorporate recent awards for AMAPCEO, Unified and Corrections

8.6 Comparison of Physician Income across Canada (Criteria 5(c))

180. Much of the focus of the issues and discussion at the bargaining and mediation has focused on Primary Care and the very public and high profile settlements in other provinces as they reform their Primary Care funding contracts or interdisciplinary team based care.

181. A factual and analytical review of these contracts in other provinces reveals that these jurisdictions were significantly behind Ontario as it related to team based primary care. As we have heard, these settlements were very much welcomed by the physicians in those provinces.

182. However, an objective and evidence based analysis of the best primary care funding contracts in the other provinces reveals that the compensation resulting from the Primary Care contracts in those provinces remain substantially behind Ontario's most lucrative Teams Based contract, that being the Family Health Organization (FHO) contract. We note parenthetically that Ontario's RNPGA compensation contract that applies to Team- Based models in the North is more lucrative than the FHO but given that there are over 6,300 physicians in the FHO contract and 109 physicians in the RNPGA contract[49], a representative comparison to the other provinces would most logically utilize the FHO contract for comparison.

(i) Methodology for Comparing GP Compensation Between Canadian Jurisdictions:

183. To ensure a fair, apples-to-apples comparison of family physician compensation between provinces, it is necessary to use the same physician workload assumptions in each province. What would a physician earn in each province if they were working in exactly the same way?

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[49] Above data is taken from 2022-23, Health Analytics and Insights Branch, MOH.

184. The first step in defining the workload for comparison is to determine the characteristics of the average physician working in Ontario's flagship payment model, the FHO. Three key measures of the average FHO physician's workload must be defined: 1) the number of enrolled patients, 2) the number of patient visits per year, and 3) an estimate of hours worked.

185. Once these three measures have been calculated, we can model the income that the average FHO physician would have earned under the payment models used in the other provinces. Comparisons will be made only to each province's flagship primary care payment model (e.g. the LFP model in BC, as opposed to their FFS model).

186. A key consideration for this analysis is that only the workload and income related to primary care work are captured. Should income related to other work (e.g. ED work, other hospital-based work) be captured, the comparison may be skewed by differences in compensation structure unrelated to the primary care models.

(ii) *Method for Workload and Compensation of the Average FHO Physician*

187. For the purposes of this analysis, the average FHO physician workload is calculated as an average across all FHO physicians (total of 6,060 physicians). The metrics which were utilized to calculate the average FHO Physician workload in 22/23 has been included in the subsequent page.

Understanding the Workload and Compensation of the Average Ontario FHO Physician in FY 2022/23:

The average FHO physician workload is calculated as an average across all FHO physicians (n = 6,060):

1. Average Number of Enrolled Patients = **1,210 patients**
2. Average Number of Primary Care Visits = **2,998 visits per year**
    - A primary care visit is defined as any encounter with a patient enrolled in the FHO group, OR an encounter with a non-rostered patient where the service was in-basket and the setting was in a physician's office
3. Average Days (Hours) Worked = **162 days (1,296 hours) per year**
    - A day worked is defined as 12 or more primary care encounters on a service day (days with fewer than 12 primary care encounters are pro-rated e.g. 6 encounters = 0.5 days). A day is assumed to be an eight hour day.

NOTE: The number of enrolled patients and primary care visits are actuals obtained from patient enrolment and physician claims datasets. The days (hours) worked metric is an estimate. We believe that 1,296 hours per year is likely an overestimate of actual hours worked, based on the fact that 1,296 hours would represent an average of 25.9 minutes per patient visit (inclusive of direct, indirect and administrative time).

For reference, primary care physicians in BC spend an average of 19.7 minutes per patient visit (inclusive of all physician activity: direct care, indirect care, and administrative time). BC data is based on actuals (i.e. publicly available data on BC's LFP payment model which pays physicians an hourly rate for all of their time).

188. The average FHO physician income from primary care work (as based on the above metrics) is $365,266. The detailed calculation is found in the table below. However, we would note that this total includes the 2.8% increase agreed to for FY2023/24. Further, this figure includes all sources of primary care compensation (e.g. capitation, shadow billing premium, CC cap, access bonus, etc.).

(iii) *Simulating FHO Physician Compensation Using Other Provincial Payment Models*

189. Six provinces are included in this analysis: Nova Scotia, British Columbia, Newfoundland and Labrador, Alberta, Manitoba, and Saskatchewan. The table below includes descriptions of key payment characteristics of each model:

Province and Model	Key Payment Characteristics
Nova Scotia Longitudinal Family Medicine **(LFM)** Payment Model	Nova Scotia's LFM model pays physicians based on their panel size, patient visit volume, and hours worked. While there are some similarities to the FHO model (both models have a capitation payment and a shadow billed component that pays a percentage of the service fee), Nova Scotia's LFM has a substantial hourly rate component. With an hourly rate of $92.70 that captures all physician activity, Nova Scotia's primary care physicians earn roughly 40% of their income based on their hourly rate billings.
British Columbia Longitudinal Family Practice **(LFP)** Payment Model	BC's LFP model has the same payment structure as Nova Scotia's model, but with a different weight attached to each of the three components. BC has a significantly lower capitation rate than Nova Scotia, but a much higher hourly rate ($130 per hour). As a result, BC physicians earn roughly 60% of their income based on their hourly rate billings.
Newfoundland and Labrador Blended Capitation Model	Newfoundland recently implemented a blended capitation model that leverages the basic structure of the FHO model. While the visit and capitation fees are roughly in line with the FHO rates, the Newfoundland model does not pay a CC Cap equivalent or an Access Bonus payment.
Alberta Fee-For-Service Model	The vast majority of primary care physicians in Alberta are on fee-for-service. In our analysis, we have used the weighted average FFS rate paid in Alberta for primary care work. We have also included recently announced retention payments for primary care physicians.
Manitoba Family Medicine Plus	Manitoba's new Family Medicine Plus model pays physicians predominantly through a visit fee and panel payment. The panel payment is based on patient age and presence of specific chronic diseases. While some of the chronic disease payments can be relatively high (over $250 per patient per year), 70% of the Ontario population does not meet the criteria for ANY chronic disease payments under the Manitoba model.
Saskatchewan Transitional Payment Model (TPM)	The Saskatchewan TPM model pays physicians the full fee-for-service rate plus a maximum of $144,000 in capitation per year. The capitation amount paid to each physician is determined based on their ratio of encounters and panel size. For payment of the full $144,000, a physician would have to have a roster of 1,600 patients and 6,500 annual visits. Under this formula, the average Ontario physician would qualify for $86,400 in capitation payments.

190. The detailed calculations for each provincial payment model, based on the workload of the average FHO physician as per the metrics above, is provided in the table that follows. The results provide the amount that the average FHO physician would have earned under each payment model.

This table provides the detailed calculations for each provincial payment model, based on the workload of the average FHO physician. The bottom row represents the amount that the average FHO physician would have earned under each payment model[50].

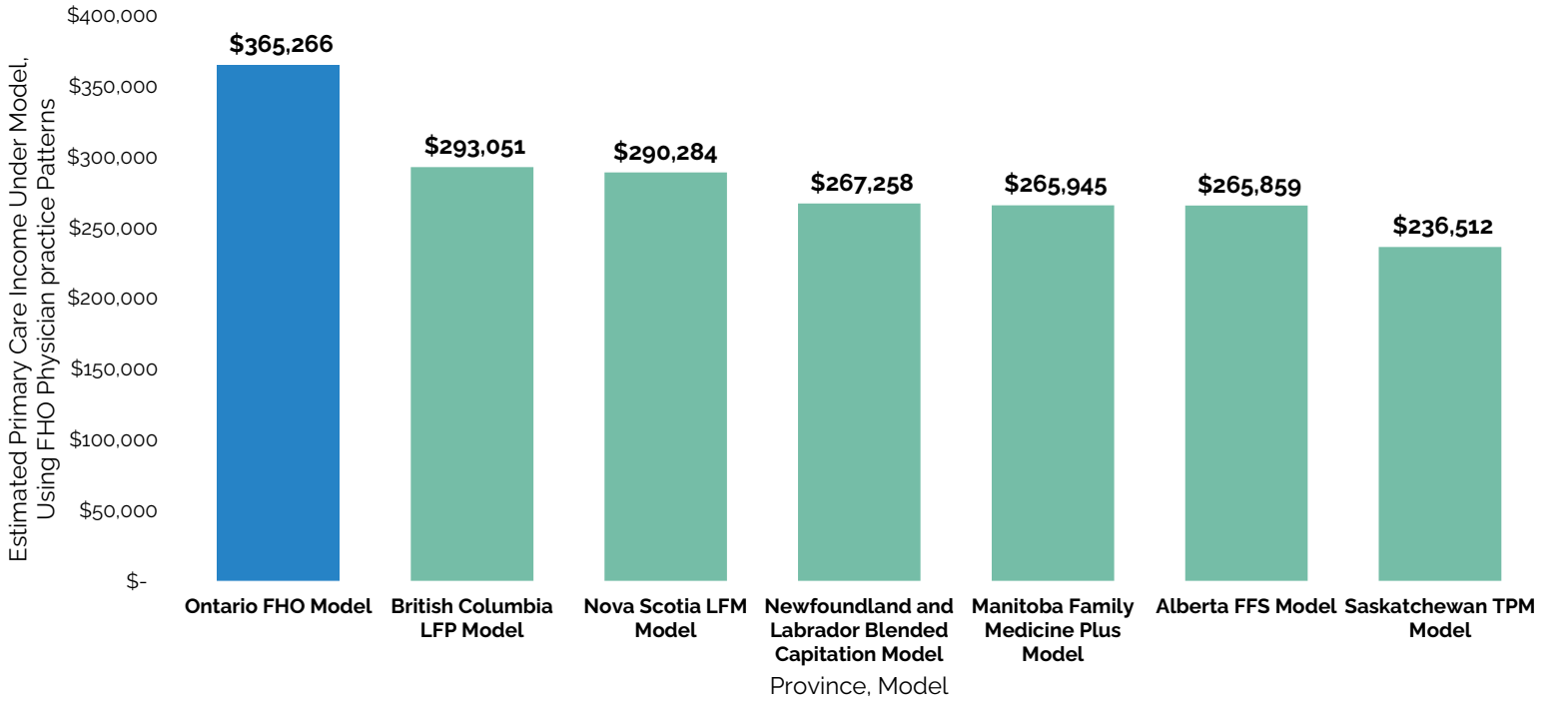
Model Element	Ontario FHO Model	British Columbia LFP Model	Nova Scotia LFM Model	Newfoundland and Labrador Blended Capitation Model	Manitoba Family Medicine Plus	Alberta FFS GP Model	Saskatchewan TPM Model
Patient Visit Payment *(Avg. FHO = 2,998 Visits per Year)*	$17.75 per visit (2,998 x $17.75 = $53,224)	$27.42 per visit[1] *(2,998 x $27.42 = $82,210)*	$15.17 per visit[2] *(2,998 x $15.17 = $45,482)*	$12.75 per visit[6] *(2,998 x $12.75 = $38,227)*	$41.18[9] *(2,998 x $41.88 = $123,465)*	$71.74[5] *(2,998 x $71.74 = $215,096)*	$49.26 per visit[3] *(2,998 x $49.26 = $147,691)*
Hourly Payment *(Avg. FHO = 1,296 Hours per Year)*	**None**	$130.00 per hour *(1,296 x $130.00 = $168,480)*	$92.70 per hour *(1,296 x $92.70 = $120,139)*	**None**	$171.04 Max. 3 Hours per Week *($171.04 x 3 x 52 = $26,682)*	**None**	**None**
Panel Size Payment *(Avg. FHO = 1,210 Enrolled Patients)*	$212.39 per patient (1,210 x $212.29 = $257,059)	$35.00 per patient *(1,210 x $35.00 = $42,361)*	$103.00 per patient *(1,210 x $103.00 = $124,663)*	$180.97 per Patient *(1,210 x $180.97 = $219,031)*[7]	$92.70[10] *(1,210 x $92.70 = $112,198)*	**None**	$73.39 per patient[4] *(1,210 x $73.99 = $88,821)*
Other Payments *(If Applicable)*	$32,437 Group Level Payments (Incl. Access Bonus) $4,988 Preventive Care Bonus $1,946 Q012A After Hours $1,414 Q040 Diabetes Management $7,000 Other Payment Elements <$1k per Physician (n = 36)	**None**	**None**	$2,500 Procedure Bonus $7,500 Quality of Care Stipend	$100.00 Tariff 8180 Newborn and Infant Enrollment Bonus *(36 Newborns per Panel x $100.00 = $3,600)*	$30,000 Physician Retention Payment $3.59 Business Cost Premium/Visit (2,998 x $3.59 = $10,763) $10,000 Panel Management Payment[8]	**None**
Total Primary Care Income	**$365,266[11]**	**$293,051**	**$290,284**	**$267,258**	**$265,945**	**$265,859**	**$236,512**

[50] Methodological notes on the calculation of each provincial payment model are contained at Exhibit 24.

191. Given the current pattern practices, family physicians in the FHO compensation model earn significantly more than they would in the other Canadian jurisdictions. The table below and bar chart on the follow page summarizes the findings:

Province	Income from Primary Care Model	$ Ontario Ahead	% Ontario Ahead
British Columbia	**$293,051**	$63,215	22%
Nova Scotia	**$290,284**	$65,982	23%
Newfoundland	**$267,258**	$89,008	33%
Manitoba	**$265,945**	$90,321	34%
Alberta	**$265,859**	$90,407	34%
Saskatchewan	**$236,512**	$119,754	51%

With current practice patters, Primary Care doctors in the FHO compensation model for Ontario earn more than they would in other comparable Canadian jurisdictions:



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9. OVERHEAD

9.1 How Businesses Have Addressed Overhead

192. Overhead is the cost of running a business. We expect the OMA will argue that these costs have gone up at an extraordinary rate in an attempt to justify an extraordinary price increase in the first year. We disagree for a number of reasons.

193. First, there is a high degree of variability with regards to the level of overhead different types of physicians have (an institution-based Emergency Medicine physician versus a community-based Family Physician).

194. Second, this issue is related in part to the issue of administrative burden. We will argue the issue of administrative burden separately.

195. Third, in anticipation of any submission that an extraordinary increase should be awarded because the rate of business costs have gone up we make the following observations:

    1. The fees paid to physicians incorporate a component attributable to overhead. The parties have not agreed to what portion of the fee is attributable to overhead, and it clearly varies by the nature of the practice. While there is a range for overhead, the OMA may say that the *average* overhead built into fees is 30%. The MOH submits that the *average* is closer to 18%. However, both parties acknowledge that the level of overhead can vary greatly by specialty and practice setting. For example, an Emergency physician or an Anesthesiologist is almost exclusively in an institution-based setting where their overhead is highly subsidized. We will review that variation of levels later in this section. However, we respectfully submit that if the Board feels that any special attention needs to be placed on this issue, the variance among practice setting would make the case that any adjustment should be targeted.

2. It is important to note that like any business, expenses are paid out of revenue and not price increases. Businesses grow their revenue to mitigate the impact of overhead. Physician businesses do the same. Physician businesses have typically grown revenue through utilization (a term the parties historically have used to describe this phenomena). Every business will have its own methods to generate this type of organic growth.

196. In order to illustrate our point, we provide examples of physician business growth. Our simple observation is that independent physician contractors have been able to generate utilization growth of above 1% over price increases year in and year out. As such, for the purpose of illustration we will conservatively assume a 1% utilization growth per year. As well, for the purposes of this illustration we will assume that the Board agrees with the MOH that 3% is an appropriate price increase in all the circumstances. If, as with a typical business, the utilization growth of 1% is used to mitigate overhead costs, the following business case analysis applies.

197. First, we provide the example for physician's practices that has a 10% level of overhead. As can be seen from the below, the Price (Base) increase of 3% offsets the first 3% of overhead. The incremental growth from utilization of 1% would, **if applied to overhead only**, equal 10 X 1% or 10% of overhead.

	Gross Revenue	**Revenue Applied to Overhead Expenses (10% Level of overhead)**
Base Income	100.00	10.00
Base Increase (3%)	3.00	0.30
Utilization Growth (1%)	1.00	1.00
Total Increase	4.00	1.30
% Total Increase	4%	1.3/10 = 13%

198. If the business overhead is 20%, the incremental growth from utilization of 1% would, **if applied to overhead only**, equal 5 X 1% or 5% of overhead as illustrated below:

	Gross Revenue	Revenue Applied to Overhead Expenses (20% level of overhead)
Base Income	100.00	20.00
Base Increase (3%)	3.00	0.60
Utilization Growth (1%)	1.00	1.00
Total Increase	4.00	1.60
% Increase	4%	1.6/20 = 8%

199. If the business overhead is 33.3%, the incremental growth from utilization of 1% would, **if applied to overhead only**, equal 3 X 1% or 5% of overhead as illustrated below:

	Gross Revenue	Revenue Applied to Overhead Expenses (33.33% level of overhead)
Base Income	100.00	33.33
Base Increase (3%)	3.00	0.90
Utilization Growth (1%)	1.00	1.00
Total Increase	4.00	1.9
% Increase	4%	1.9/33.33 = 5.7%

200. The analysis below illustrate a wide range of overhead[51].

[51] Methodological Notes on the Overhead Analysis at Exhibit 25

201. The Ministry's physician income relativity model (RAANI) estimates physician overhead using a bottom-up approach, where a unique overhead value is calculated for each physician based on their type of practice, practice location, specialty, and workload.

202. The key components of overhead that are estimated in the model include:

    (i) Leasing Costs: Estimated using the size requirements of the office space and the leasing rate of the location

    (ii) Staffing Costs: Estimated using administrative and clinical staffing ratios

    (iii) Operating Costs: Includes annual costs such as insurance, membership dues, medical supplies and professional services

    (iv) Capital Costs: Represents basic equipment requirements of medical offices such as instruments and furniture as well as IT requirements (e.g. computers and printers)

    (v) Specialty Specific Equipment and Supplies: Includes costs for specific equipment required for specialties with unique costs and technical requirements.

203. For each of these overhead components, external research was used to generate cost estimates for a full-time physician practicing in a physician office and a full-time physician practicing in an institution-based setting. From there, an overhead value for each physician was estimated based on the share of their work in an office setting vs. institution-based setting.

204. One of the key features of the RAANI overhead model is that it accounts for differences in overhead between physicians practicing in different settings. As can be seen from the table below, 35% of physicians practice in an office setting, 34%

practice in an institution (e.g. hospital) setting, and 31% practice in both offices and institutions ("mixed setting").

Specialty Group	Physician Office	Institution	Mixed Setting
Anaesthesia	63	1,143	268
Cardiology	118	212	386
Cardiovascular and Thoracic Surgery	4	114	36
Clinical Immunology	44	12	15
Dermatology	179	20	42
Diagnostic Radiology	157	686	391
Emergency Medicine	12	422	68
Endocrinology	109	87	101
Family Practice and Practice in General	7,966	2,355	3,730
Gastroenterology	30	100	198
General Surgery	53	375	424
Geriatrics	10	118	53
Haematology	4	173	79
Infectious Disease	4	147	41
Internal Medicine	271	1,061	491
Medical Oncology	16	139	124
Nephrology	7	123	115
Neurology	87	252	168
Neurosurgery	4	91	24
Nuclear Medicine	7	34	8
Obstetrics and Gynaecology	148	247	589
Ophthalmology	150	71	249
Orthopaedic Surgery	25	320	315
Otolaryngolgy	38	67	177
Paediatrics	462	731	479
Physical Medicine	60	96	82
Plastic Surgery	56	90	106
Psychiatry	637	925	502
Radiation Oncology	26	182	19
Respiratory Disease	28	124	173
Rheumatology	135	68	46
Thoracic Surgery	17	115	191
Vascular Surgery	3	26	56
Grand Total	**10,930**	**10,726**	**9,746**
	35%	*34%*	*31%*

205. The average overhead of physicians practicing in an office setting is estimated to be $107,668, while the average overhead of physicians practicing in an institution-based setting is estimated to be $37,767. The table below provides a breakdown of average cost per physician for each of these two settings.

	Physician Office	Institution
Leasing Costs		
Lease Cost	$31,994	$5,157
Cleaning Cost	$2,007	$324
HST (only to lease cost)	$4,159	$670
Total Leasing Cost	**$38,160**	**$6,151**
Staffing Costs (annual cost, 23% benefits)		
Medical Office Assistant (0.33 FTE)	$15,173	$12,135
Receptionist (0.33 FTE)	$15,172	$47
Registered Nurse (0.08 FTE)	$7,781	$0
Registered Practical Nurse (0.1 FTE)	$6,366	$0
Total Staffing Cost	**$44,492**	**$12,182**
Operating Costs (annual cost)		
Professional Dues	$6,096	$6,096
Supplies (one year)	$3,896	$3,116
Accounting	$2,500	$2,500
Parking	$800	$800
Insurance (non-CMPA)	$4,243	$4,243
Net CMPA fees	$1,205	$2,659
Total Operating Costs	**$18,740**	**$19,415**
Capital Costs (annual cost)		
Furniture (10-year amortization)	$2,536	$8
Equipment (10-year amortization)	$3,413	$10
Instruments (5-year amortization)	$327	$1
Total Capital Costs	**$6,276**	**$18**
Average Total Overhead Cost per Physician	**$107,668**	**$37,767**

The table below shows the average gross income per physician and average estimated overhead per physician for each specialty.

	Average Gross Income per Physician			Average Estimated Overhead per Physician		
Specialty Group	**Physician Office**	**Institution**	**Mixed Setting**	**Physician Office**	**Institution**	**Mixed Setting**
Anaesthesia	$677,655	$524,719	$540,258	$99,941	$43,772	$70,837
Cardiology	$654,538	$564,783	$793,222	$113,850	$39,403	$97,334
Cardiovascular and Thoracic Surgery	$498,234	$628,135	$680,294	$98,641	$47,816	$86,052
Clinical Immunology	$467,307	$454,707	$369,679	$102,153	$33,842	$72,857
Dermatology	$422,061	$276,456	$444,952	$104,022	$30,031	$86,048
Diagnostic Radiology	$645,950	$708,711	$974,903	$107,141	$41,393	$78,546
Emergency Medicine	$994,912	$308,890	$408,601	$112,497	$35,004	$73,727
Endocrinology	$447,771	$249,595	$394,436	$104,891	$30,768	$89,706
Family Practice and Practice in General	$387,007	$275,176	$379,641	$110,856	$36,427	$87,947
Gastroenterology	$773,686	$504,858	$765,458	$103,739	$33,994	$76,613
General Surgery	$719,973	$405,149	$559,411	$106,877	$40,165	$74,790
Geriatrics	$236,534	$340,357	$257,345	$90,468	$35,169	$66,937
Haematology	$375,923	$369,647	$465,286	$103,135	$37,688	$86,578
Infectious Disease	$504,161	$235,611	$347,541	$121,416	$32,642	$65,944
Internal Medicine	$470,573	$351,699	$455,605	$99,106	$36,413	$77,801
Medical Oncology	$582,598	$689,135	$511,024	$107,397	$43,307	$90,752
Nephrology	$622,722	$532,159	$683,471	$109,198	$40,132	$81,379
Neurology	$318,651	$296,747	$353,435	$95,235	$34,448	$85,683
Neurosurgery	$1,056,777	$682,850	$652,859	$113,227	$46,502	$65,314
Nuclear Medicine	$760,823	$417,326	$498,099	$115,005	$38,599	$76,290
Obstetrics and Gynaecology	$400,683	$395,318	$466,246	$106,585	$42,004	$99,166
Ophthalmology	$863,685	$697,528	$959,368	$145,638	$35,456	$138,515
Orthopaedic Surgery	$328,260	$496,291	$577,727	$90,311	$43,253	$71,159
Otolaryngolgy	$403,674	$538,844	$524,262	$99,813	$38,817	$101,569
Paediatrics	$333,456	$294,544	$356,107	$103,779	$30,887	$78,513
Physical Medicine	$424,342	$309,308	$352,047	$103,017	$35,791	$79,720
Plastic Surgery	$319,530	$423,195	$446,425	$97,769	$39,414	$78,110
Psychiatry	$219,143	$278,658	$281,785	$71,893	$34,358	$62,558
Radiation Oncology	$646,281	$584,774	$488,423	$108,548	$40,340	$84,224
Respiratory Disease	$502,134	$342,658	$456,313	$114,269	$37,197	$97,637
Rheumatology	$379,344	$269,254	$358,510	$108,338	$33,105	$95,612
Thoracic Surgery	$241,828	$545,549	$534,094	$80,511	$42,656	$90,316
Vascular Surgery	$632,882	$533,111	$716,495	$114,523	$41,463	$96,626
Grand Total	**$397,650**	**$395,468**	**$480,814**	**$107,668**	**$37,767**	**$85,698**

206. The estimated overhead per physician varies significantly between practice settings. For example, the average overhead of family physicians practicing in the office setting is estimated to be 29%, while the average overhead of family physicians practicing in institution-based settings is 13%. Similar variation can be seen between specialties.

Specialty Group	Physician Office	Institution	Mixed Setting	Average (All Settings)
Anaesthesia	15%	8%	13%	**10%**
Cardiology	17%	7%	12%	**12%**
Cardiovascular and Thoracic Surgery	20%	8%	13%	**9%**
Clinical Immunology	22%	7%	20%	**19%**
Dermatology	25%	11%	19%	**23%**
Diagnostic Radiology	17%	6%	8%	**8%**
Emergency Medicine	11%	11%	18%	**12%**
Endocrinology	23%	12%	23%	**21%**
Family Practice and Practice in General	29%	13%	23%	**25%**
Gastroenterology	13%	7%	10%	**10%**
General Surgery	15%	10%	13%	**12%**
Geriatrics	38%	10%	26%	**15%**
Haematology	27%	10%	19%	**13%**
Infectious Disease	24%	14%	19%	**16%**
Internal Medicine	21%	10%	17%	**14%**
Medical Oncology	18%	6%	18%	**11%**
Nephrology	18%	8%	12%	**10%**
Neurology	30%	12%	24%	**19%**
Neurosurgery	11%	7%	10%	**8%**
Nuclear Medicine	15%	9%	15%	**12%**
Obstetrics and Gynaecology	27%	11%	21%	**20%**
Ophthalmology	17%	5%	14%	**14%**
Orthopaedic Surgery	28%	9%	12%	**11%**
Otolaryngolgy	25%	7%	19%	**17%**
Paediatrics	31%	10%	22%	**20%**
Physical Medicine	24%	12%	23%	**19%**
Plastic Surgery	31%	9%	17%	**17%**
Psychiatry	33%	12%	22%	**20%**
Radiation Oncology	17%	7%	17%	**9%**
Respiratory Disease	23%	11%	21%	**18%**
Rheumatology	29%	12%	27%	**25%**
Thoracic Surgery	33%	8%	17%	**14%**
Vascular Surgery	18%	8%	13%	**12%**
Average Overhead (All Specialties)	**27%**	**10%**	**18%**	**18%**

10. ADMINISTRATIVE BURDEN

10.1 Overview

207. We expect that arguments regarding the impact of administrative burden will form part of the OMA arguments for an extraordinary overall price increase.

208. Interestingly this is a new issue in this round of negotiations. The concept of administrative burden did not form part of the discussions or arbitration in the first round of negotiation and arbitration under the BAF and was not a topic of discussions or negotiations in the second round of negotiations under the BAF which resulted in the voluntarily agreed 2021 PSA.

209. The OMA may reference statistics on the amount of time a physician spends on administrative work based on a survey conducted in 2023 by the Ontario College of Family Physicians (OCFP). However, for context, we submit that there is data that this Board can consider based on hours actually billed by physicians instead of self reported data.

210. British Columbia has published the "Medical Service Plan: Fee-For-Service Payment Analysis 2018/19 to 2022/2023"[52] which summarizes services and expenditure by fee item for each fiscal year. This report contains the expenditure for time-based codes under BC's Longitudinal Family Practice (LFP) Payment Model. As all time-based codes are billed in 15 minute increments, a mathematical formula can determine the amount of time a physician in the LFP model spends on indirect/administrative work based on their billings (the methodological breakdown is at Exhibit 12). The BC experience to date is that 24% of a family physicians time is spent on indirect patient care/administrative work. We can be

[52] https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msp_ffs_payment_analysis.pdf

reasonably certain that the BC doctors are capturing all of their administrative time in this brand new model.

211. Based on an overgenerous assumption that the average Family Physicians perform 40 hours of work per week (see the section at page 84 with respect to the average hours worked of a FHO physicians), this would produce a weekly average of 9.6 hours spent on administrative tasks.

212. We respectfully submit that the issues and debate around the question of administrative burden should not form a basis for an extraordinary price increase for the following reasons:

(i) If increased administrative work is taking away precious physician time from clinical work it is a problem that should be addressed by the parties and resolved so that our highly skilled and trained physicians can apply themselves to the work they are trained for, patient care. Resolving this issue will result in more patient visits, better access to care, higher physician income from their fee for service performed and possibly improved work-life balance.

(ii) If increased administrative work is impacting a physician's "work life balance", it is a problem that should be resolved by the parties so that the physician can free up time for family, friends and other outside interests and refresh the physician to provide a break from work to recover and provide the best level of care when they are working.

(iii) If this described increase in administrative work is creating burnout or moral distress as the physician's patients are concerned and complaining of wait times or lack of access, the problem should be addressed by the parties to mitigate or eliminate this impact.

(iv) Given the very recent advent of this issue at the bargaining table, it is premature and inappropriate to address this problem with permanent price increases as the major sources of the problems would continue, and higher incomes would do nothing to solve the core problem. Conversely, if the administrative burden issue is alleviated, and a permanent increase is awarded, this administrative component would still be embedded in the permanent price increase while the burden no longer exists. This award is for one year, and more time is need for the parties to address this issue.

(v) It would be inappropriate to address this problem by payment for administrative work. First and most importantly, the fee system should not incent such work as it does little to improve patient access and perpetuates the existing problem. Second, the great training and related skills enjoyed by physicians would be wasted on administrative work that does not require the same training and skill.

(vi) While some provinces have added fees for administrative work to their primary care compensation packages, we note that the compensation levels for these new contact payment model which contain these features are not as generous as the preferred Ontario primary care comprehensive contact, the FHO contract.

(vii) If, ultimately, the parties agree or the Arbitration Boad decides that some payment should be made for administrative work, that payment should be part of a targeted investment, not part of the general price increase.

(viii) Ultimately, the MOH has been working diligently on ideas and methods to reduce administrative burden and many of those projects are bearing fruit or on a path to do so in the near future.

(ix) In concluding we note that in those situations where this issue appears most acute according the OMA (primary care physicians), our capitation model already bakes administrative time into the capitation fee.

10.2 MOH Initiatives to Reduce Administrative Burden

213. The MOH is taking action to reduce administrative burden for physicians. The government initiative called “Patients Before Paperwork” (Pb4P) specifically aims to reduce the administrative burden of frontline providers by creating a more seamless, digitally connected system that health care providers can leverage to plan, coordinate and deliver patient care.

214. The PB4P initiative has already accomplished a number of digital improvements:

1. The identification of a priority bundle of digital tools to reduce fax use and thus the time clinicians spend on such tasks as referrals and prescriptions;

2. The launch of a Hospital Report Manager (HRM) pilot initiative which implemented standards at acute care facilities to reduce the frequency and duplication of hospital reports that physicians receive and review;

3. The launch of a provincial procurement for ereferral solutions, a step forward to scaling ereferral solutions and central intake models to reduce physician time spent accessing specialized services.

215. However, what may particularly be the most impactful in reducing physician administrative burden is use of Artificial Intelligence (AI) tools to transcribe patient physician conversation and general clinical documentation, reducing physician efforts in this regard.

216. AI scribe, also known as an ambient scribe, is a technology that converts dialogue between provider and patient into text using machine learning and natural language processing to extract key data from the text. It is intended to work as a digital assistant to health care providers, enhancing and assisting with completing patient charting and improving the accuracy and completeness of clinical documentation, which are essential for patient safety, quality improvement, billing, and compliance.

217. As an example, a physician may initiate the AI scribe during a clinical encounter with a patient by pressing one button on their computer. The AI scribe will then being to generate the clinical note. The technology has the ability to ignore interruptions and potentially extraneous information such as “small talk” not relevant for documentation purposes. The technology also has the ability to translate, allowing patients to speak in a language other than English and still be understood. While this is the current reality of the technology, AI is poised to play an increasingly more prominent role in medicine. Advancements in the technology are already being made in AI applications which automatically generate suggestions on forms to be filled out, referrals to be made, ordering tests and prescribing medications.

218. The MOH, in partnership with its delivery partner Ontario Health) OntarioMD , and the eHealth Centre of Excellence, is working on an AI scribe pilot project. We remind the Board that OntarioMD is a wholly owned subsidiary of the OMA and receives funding from the Province of Ontario. The current AI scribe pilot aims to complete a meaningful assessment by the end of fiscal year 2023/2024, reaching 100-150 primary and community care physicians. The pilot identified a broad spectrum of primary and community care physicians who differ in both age and time spent in practice.

219. Initial results from Ontario have demonstrated that physicians are experiencing a timesaving of up to 30% (up to 29 hours/month) when using an AI based scribe to record and transcribe the patient physician conversation. The initial feedback from providers is that they saw reduced administrative burden, cognitive fatigue and after hours charting, particularly for more complex clinical encounters. The providers also found improved patient-centered care and an increased quality of care and diagnostic accuracy (Exhibit 13)

220. A quote from a physician participating in the AI Scribe pilot is reproduced below:

> “I have joy going to work.

> I have joy practicing because this … regulation of charting everything has now been alleviated and I just, I'm happy. This is the first Christmas in [20+ years] that I haven't had to spend time catching up on my notes…
>
> Yeah, it's, it's really… I have decided, I'm a later physician in terms of my career, that I'm gonna practice for another 10 years at least, and that will bring me well past 65.
>
> So this has been a game changer for me personally."

221. We also provide the below quote of Mohamed Alarakhia, a Family Physician and CEO of the eHealth Centre of Excellence[53]:

> "Using an AI Scribe has allowed me to focus more on listening to a patient's concerns and working collaboratively to develop a management plan. It has significantly reduced the burden of documentation so I can serve my patient better. Primary Care Providers need these types of supports so they can spend more time with patients."

222. The positive findings from the pilot appear to align with the experience of other jurisdictions. The American Medical Association recent published an article with the findings that "AI Scribe" saves doctors an hour at the keyboard every day. This was based on The Permanente Medical Group's rollout of the AI scribe to physicians in Northern California.

223. A number of Ontario physicians have likely already tried and implemented AI Scribe outside of the Pilot Project noted above. This is certainly the case for Physicians in the United States. For example, one survey from the United States found that 33% of primary care physicians surveyed had already trialed AI Scribe technology[54].

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[53] https://news.ontario.ca/en/release/1004479/ontario-helping-family-doctors-put-patients-before-paperwork

[54] https://financialpost.com/pmn/business-wire-news-releases-pmn/1-in-3-primary-care-physicians-have-already-tried-ai-scribe-tools-outlook-is-cautiously-optimistic-finds-elation-health-survey

224. That is not to say that AI scribe is without its limitations. Like any technological advancements, it requires a learning curve. However, the providers in the AI scribe pilot have proven the learning curve is not arduous, and that once the effective use of the AI scribe is understood, the benefits to the physician are exponential.

225. The findings from the Ontario pilot will be used to inform the provincial AI Scribe spread and scale of the program. However, it seems certain that AI has a role to play in medicine and the evidence from Ontario clinicians participating in the pilot program suggests it will have a meaningful impact in the reduction of physician administrative burden.

226. The Ontario government is also working with the OMA on the streamlining and simplifying of 12 key government medical forms that require physician time, as well as digitizing and integrating more forms into electronic medical records.

227. Finally, the Ontario Government has announced on April 24, 2024[55] that they will be making changes to encourage employers to use other tools instead of sick notes. Specifically, the proposed changes would prohibit employers from requiring sick notes from qualified health practitioners in order for employees to take entitled sick leaves, thus saving physician's time.

228. The Patients Before Paperwork initiatives has and will continue to reduce the administrative work of physicians, thereby increasing the time physicians can spend with patients, allowing enhanced patient access while also increasing the patient experience.

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[55] https://news.ontario.ca/en/release/1004479/ontario-helping-family-doctors-put-patients-before-paperwork

229. Furthermore, we submit that certain physician compensation models provide compensation for elements that could perhaps be attributable to administrative tasks. We illustrate by reference to the OMA opening proposal in this round of negotiations to increase the Comprehensive Care Capitation Payment (e.g. a significant component of the FHO and FHG payment contract). We quote from their proposal below, which attributes the Comprehensive Care Capitation Payment to administrative requirements of physicians:

> Background:
>
> The CCC fee is a key component that led to the stabilization of primary care. It is an on-going comprehensive care management fee per month to provide for the co-ordination and management of patients' overall care. This management fee is age/sex adjusted **in recognition** that the management of the care of the elderly has become increasingly complex due to numerous diagnostic tests, procedures, allied health professional/social service communications and associated unremunerated forms required from family physicians acting in the care coordinator role.
>
> Increasing this fee will improve attachment to physician's practice and enable the physician to be better supported in all areas of their providing both indirect and direct patient care.

230. This OMA proposal will be an issue discussed in Years 2, 3 and 4 of this four year PSA.

11. OTHER CONSIDERATIONS

11.1 Where do Physicians Stand in Ontario

231. Physicians are remunerated at a rate significantly higher than the average Ontarian. The following CRA data is for all Ontario tax filers in 2022 with a non-zero employment income. The CRA has all Ontario tax filers categorized on the basis of T4 earnings and then divided them into 20 equal sized groups. Further methdological notes for the CRA data can be found at Exhibit 14.

BY AGE GROUP 20-65 FOR EMPLOYMENT INCOME (T4 DATA – BOX 14) NOT EQUAL $0 ALL ONTARIO – 2022 TAX YEAR				
EMPLOYMENT INCOME (T4 DATA – BOX 14) NOT EQUAL $0				
PERCENTILE	**COUNT OF INDIVIDUALS**	**TOTAL**	**MEAN**	**MEDIAN**
5	**359,710**	$500,003,000	$1,390	$1,260
10	**360,590**	$2,020,800,000	$5,605	$5,585
15	**358,830**	$3,761,754,000	$10,485	$10,495
20	**364,910**	$5,634,435,000	$15,440	$15,400
25	**354,510**	$7,324,144,000	$20,660	$20,630
30	**359,710**	$9,384,220,000	$26,090	$26,035
35	**359,710**	$11,363,863,000	$31,590	$31,570
40	**359,710**	$13,270,033,000	$36,890	$36,865
45	**359,710**	$15,124,586,000	$42,045	$42,015
50	**359,710**	$16,971,907,000	$47,180	$47,185
55	**359,710**	$18,864,859,000	$52,445	$52,415
60	**359,710**	$20,919,138,000	$58,155	$58,150
65	**359,710**	$23,137,407,000	$64,320	$64,355
70	**359,710**	$25,589,333,000	$71,140	$71,075
75	**359,710**	$28,448,902,000	$79,090	$79,035
80	**359,710**	$31,859,734,000	$88,570	$88,500
85	**359,710**	$35,830,149,000	$99,610	$99,900
90	**359,710**	$40,635,142,000	$112,965	$112,580
95	**359,710**	$49,536,364,000	$137,710	$136,365
100	**359,710**	$101,541,866,000	$282,285	$204,630
Total	**7,194,230**	$461,718,639,000	$64,180	$49,810

232. We contrast the above CRA data with the income of the average income of physicians:

The average physician gross payments in 2022/23		($448,829) is:
9.5X	the 50th percentile mean	($ 47,180)
1.6X	the 100 percentile mean	($282,285)
9X	the overall median	($ 49,810)
7X	the overall mean	($ 64,180)

233. Recasting the table to simply start at the 50th percentile and remove all Tax Filers which are below that 50% cutoff, we find the following:

BY AGE GROUP 20-65 FOR EMPLOYMENT INCOME (T4 DATA – BOX 14) NOT EQUAL $0 ALL ONTARIO – 2022 TAX YEAR				
EMPLOYMENT INCOME (T4 DATA – BOX 14) NOT EQUAL $0				
PERCENTILE	**COUNT OF INDIVIDUALS**	**TOTAL**	**MEAN**	**MEDIAN**
50	**359,710**	$16,971,907,000	$47,180	$47,185
55	**359,710**	$18,864,859,000	$52,445	$52,415
60	**359,710**	$20,919,138,000	$58,155	$58,150
65	**359,710**	$23,137,407,000	$64,320	$64,355
70	**359,710**	$25,589,333,000	$71,140	$71,075
75	**359,710**	$28,448,902,000	$79,090	$79,035
80	**359,710**	$31,859,734,000	$88,570	$88,500
85	**359,710**	$35,830,149,000	$99,610	$99,900
90	**359,710**	$40,635,142,000	$112,965	$112,580
95	**359,710**	$49,536,364,000	$137,710	$136,365
100	**359,710**	$101,541,866,000	$282,285	$204,630
Total	**3,956,810**	$393,334,801,000	$99,407	$79.035

234. We now do the analysis against the data which includes only the top 55% of Ontario tax filers. This removes 45% of the lower income tax filers from the analysis.

The average physician gross payments in 2022		($448,829) is:
5.7X	the 50th percentile median of the top 55%	($79,035)
4.5X	the 50th percentile mean of the top 55%	($99,407)

235. Recasting the analysis to simply start at the 70th percentile and remove all Tax Filers which are below that 70% cutoff, we find the following:

BY AGE GROUP 20-65 FOR EMPLOYMENT INCOME (T4 DATA – BOX 14) NOT EQUAL $0 ALL ONTARIO – 2022 TAX YEAR				
EMPLOYMENT INCOME (T4 DATA – BOX 14) NOT EQUAL $0				
PERCENTILE	**COUNT OF INDIVIDUALS**	**TOTAL**	**MEAN**	**MEDIAN**
70	**359,710**	$25,589,333,000	$71,140	$71,075
75	**359,710**	$28,448,902,000	$79,090	$79,035
80	**359,710**	$31,859,734,000	$88,570	$88,500
85	**359,710**	$35,830,149,000	$99,610	$99,900
90	**359,710**	$40,635,142,000	$112,965	$112,580
95	**359,710**	$49,536,364,000	$137,710	$136,365
100	**359,710**	$101,541,866,000	$282,285	$204,630
Total	**2,517,970**	$313,441,490,000	$124,482	$99,900

236. We now do the analysis against the data which includes only the top 35% of Ontario tax filers. This removes 65% of the lower income tax filers from the analysis.

The average physician gross payments in 2022		($448,829) is:
4.5X	the 50th percentile median of the top 35%	($99,900)
3.6X	the 50th percentile mean of the top 35%	($124,482)

12. PHYSICIAN CLINICAL ACTIVITY AND PATIENT ACCESS

12.1 The Ontario Experience with Physician Clinical Activity and Patient Access

237. Before this Board is a Ministry proposal for a fair and normative increase to price. This reflects what the MOH submits is a reasonable adjustment against existing labour trends and comparators. To the extent that before this Board is an OMA proposal for extraordinary increase, this section contains the historical data around patient access to physician clinical care and demonstrates that there is no correlation between patient access and physician compensation.

238. Earlier we noted that physicians are an important part of an integrated team of care providers along with other service providers like Nurse Practitioners and Pharmacists when it comes to Ontarians and their ability to access primary care. This wholistic approach to primary care is patient centred and focuses on the right care provider in the right circumstances. It also considers the convenience of access to care. Lastly, it reflects the reality of physician productivity within this integrated model. The Ministry submits that the physician supply and the physician supply pipeline is well in hand is not at a crises level akin to the one this Board Chair found in another case.

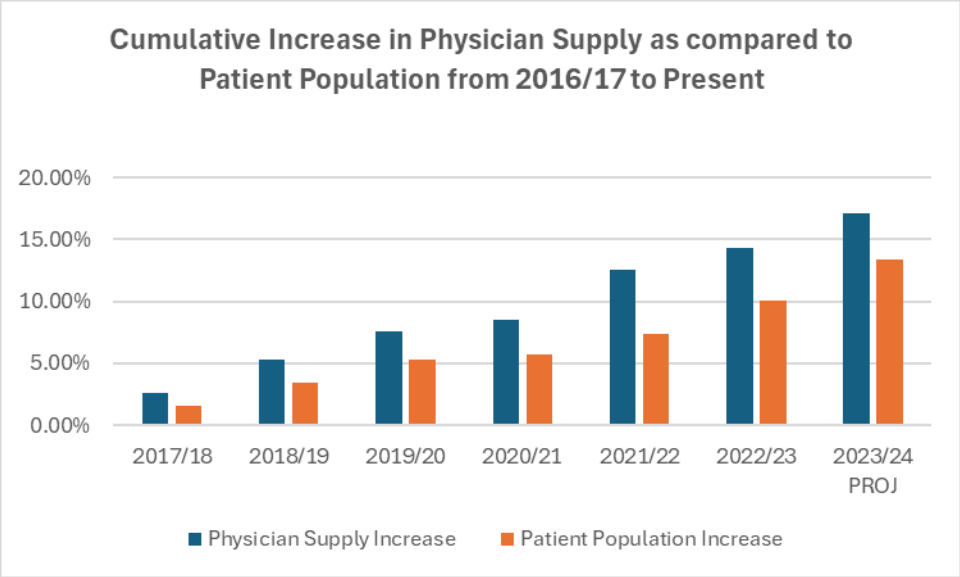
239. The number of physicians has increased at a greater rate than population. Physicians have also increased their income significantly above the negotiated compensation adjustments. The MoH submits that if you accept the above to be true, this leaves for the Board's consideration the following questions in the face of the MOH's proposed 3% price increase: Is there a need for even extraodirary award that is intended to achieve the creation of more physicians? Would such an award even be able to achieve that? Would it work and will an extraordinary general price increase positively impact patient access and patient attachment? For the reasons we note below, we submit that the answer to these questions is no. Given this, we submit that the Ministry's proposed fee increase is appropriate

in the circumstances when the evidence before the Board is considered in light of the criteria of the BAF.

240. Note that in spite of successive fee increases and overall increases in billing revenue over many years, he number of unique patients seen per physician and the number of patient encounters per physician in Ontario has decreased over time. This data is reviewed in greater detail below.

(a) The Number of Physicians Have Increased at a Far Greater Rate than Population

241. The evidence shows that the number of physicians has increased at a far greater rate than the Ontario population. The number of physicians in Ontario increased by 17.1% from 30,916 physicians in 2016/17 to 36,204 physicians projected in 2023/24[56]. In contrast, the population increased 13.4% over this same time period. The chart below and table on the follow page displays the growth in physician supply outpacing the patient population during this time period.



[56] Physician Supply (headcount) captures all physicians with at least once claim billed within the fiscal year

Physician Supply (Headcount) compared to Patient Population

Year	Physician Supply	Physician Supply Increase (Cumulative)	Patient Population[57]	Patient Population Increase (Cumulative)
2016/201	30916		13975516	
2017/201	31728	2.63%	14199811	1.60%
2018/201	32567	5.34%	14449986	1.60%
2019/202	33250	7.55%	14718155	3.40%
2020/202	33548	8.51%	14772726	5.31%
2021/202	34791	12.53%	14999441	5.70%
2022/202	35324	14.26%	15378179	7.33%
2023/202	36204	17.10%	15848654	13.40%

242. A further historical pattern from 2005/2006 with respect to this is attached at Exhibit 15.

[57] Not everyone who comes to Ontario is eligible or registers with OHIP. For example, Refugee claimants and international students are not eligible for OHIP coverage.

[58] 2023/2024 headcount is projected based on the multiplier between the headcount in the first six months of the year (with complete data) to the full year. The multiplier is calculated for FY 2022-23, and is then applied to 2023-24.

(b) Increased Physician Income Has Not Resulted in Greater Access

243. Historically, the incomes for physicians have increased greater than the negotiated or awarded "across the board" fee increases. Using the average expenditure per physician as an equivalent to physician income, the below chart clearly demonstrates that this has been the case over the course of the 2021 PSA.

Total Expenditure, Physician Count, and Expenditure per Physician; FY 2019-20 vs. FY 2023-24 (Source: ON Claims Data, MOH Expenditure Data)

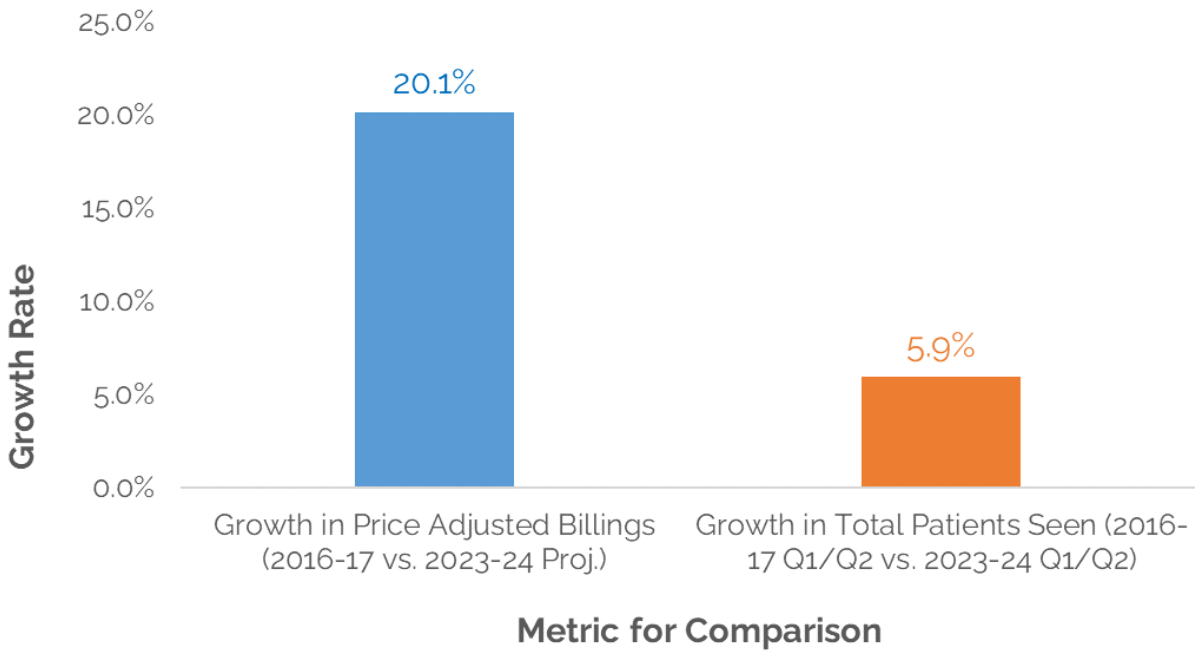
Fiscal Year	Total Expenditure	Physician Count	Expenditure per Physician
2019-20	$ 14,177 M	33,250	$ 426,382
2023-24 (F)	$ 16,985 M	36,204	$ 469,144
% Increase from 2019-20 to 2023-24	**19.8%**	**8.9%**	**10.0%**

Source:
Expenditure per Physician is calculated by Total Expenditure / Physician Count
2023-24 Physician Count is projected using Q1+Q2 values

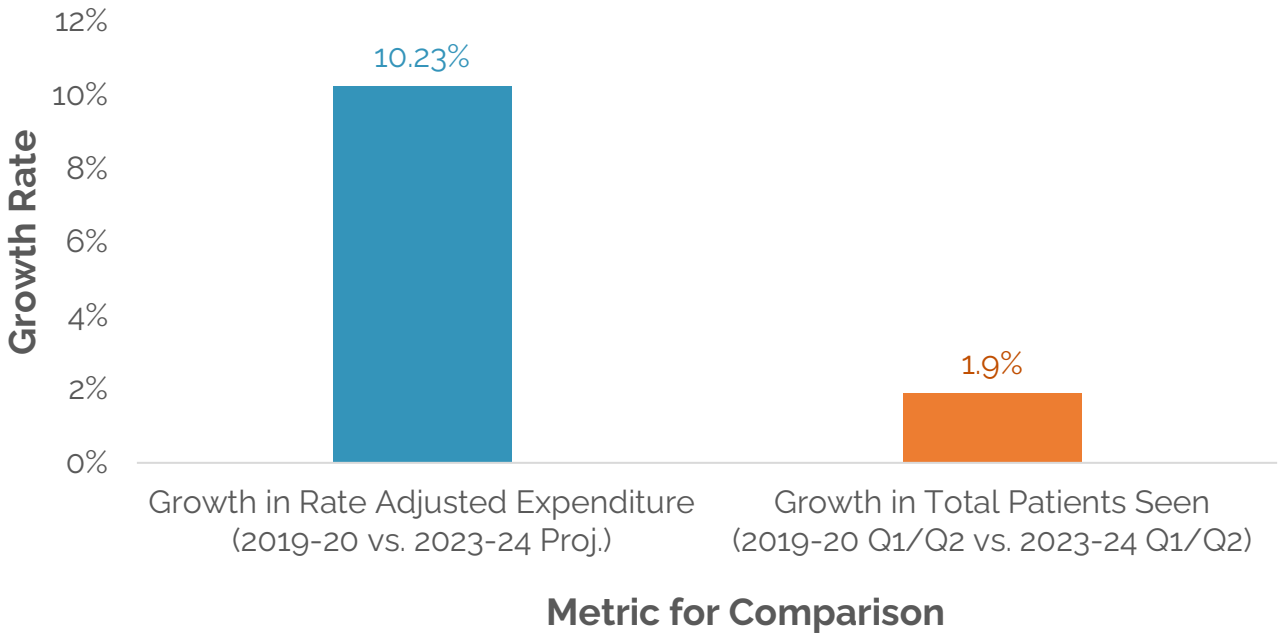
244. The average income of a physician (expenditure per physician) increased by ~10% from 2019-20 to 2023-24.

(c) Growth in Rate-Adjusted FFS and Shadow Billings Has Far Exceeded Growth in Patients Seen

245. The increases in physician expenditure is not due to physicians undertaking more patient visits. The below chart adjusts the physician expenditure from 2016/17 to 2023/24 by removing the impact of fee increases. It demonstrates that the increase in physician FFS and shadow billings during this time period was 20.1% aside from fee increases. The net result is that physician incomes overall are, in fact, higher than the fee increases. Physicians have been able to increase their incomes outside of fee adjustments. Curiously, over the same time period, the total growth in the distinct patients seen for physicians only increased by 5.9%. It does not appear that the increased physician income is due to physicians increasing the number of patients they are seeing.



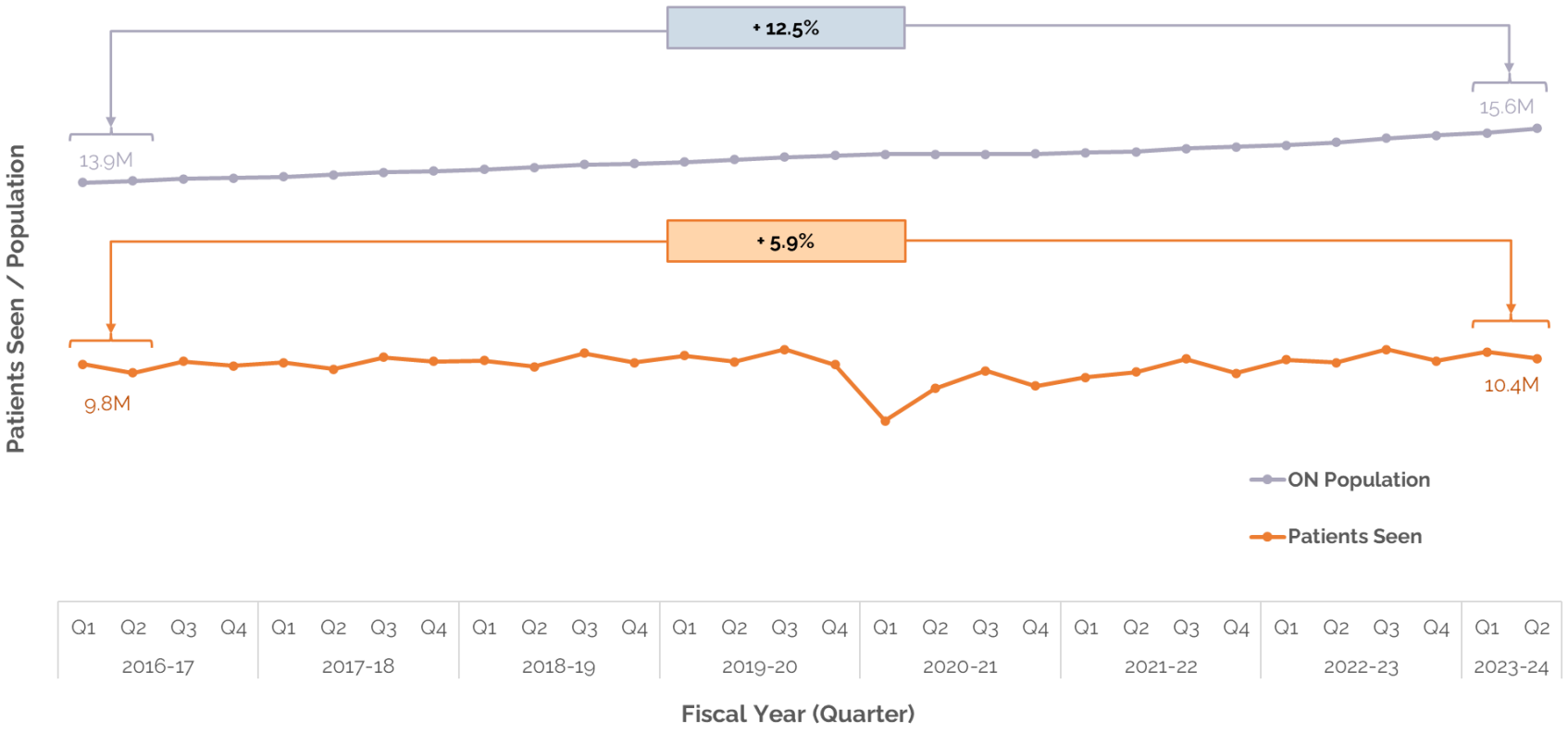
246. When adjusted for the 2019/2020 time period instead, the result is even similar. It demonstrates that the increase in physician FFS and shadow billing during this time period was 10.23% aside from fee increases. Over the same time period, the total growth in the distinct patient seen for physicians only increased by 1.9%.



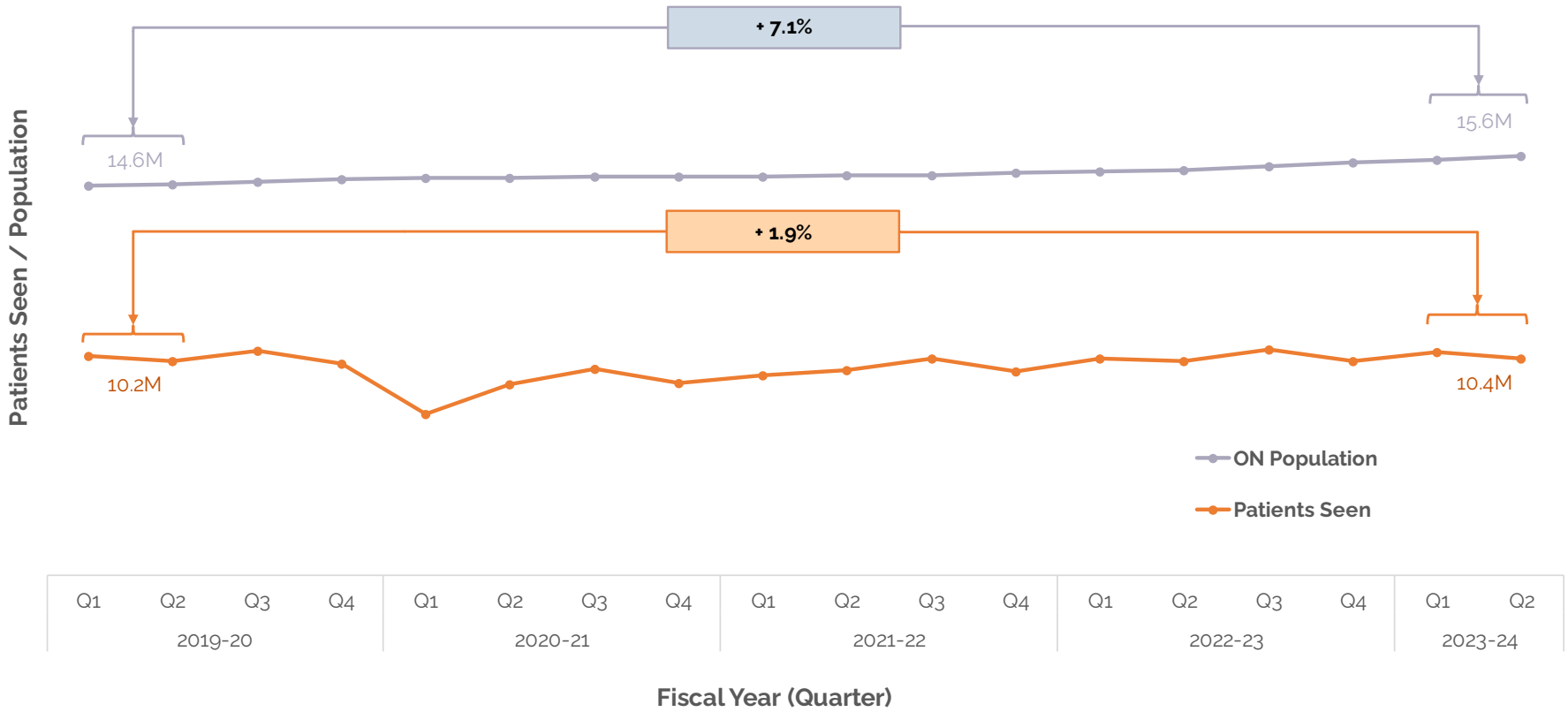
247. A further historical pattern from 2005/2006 with respect to this is attached as well at methodological notes are attached at Exhibit 15.

(d) Ontario Population Growth has Exceeded the Number of Patients Seen by Physicians

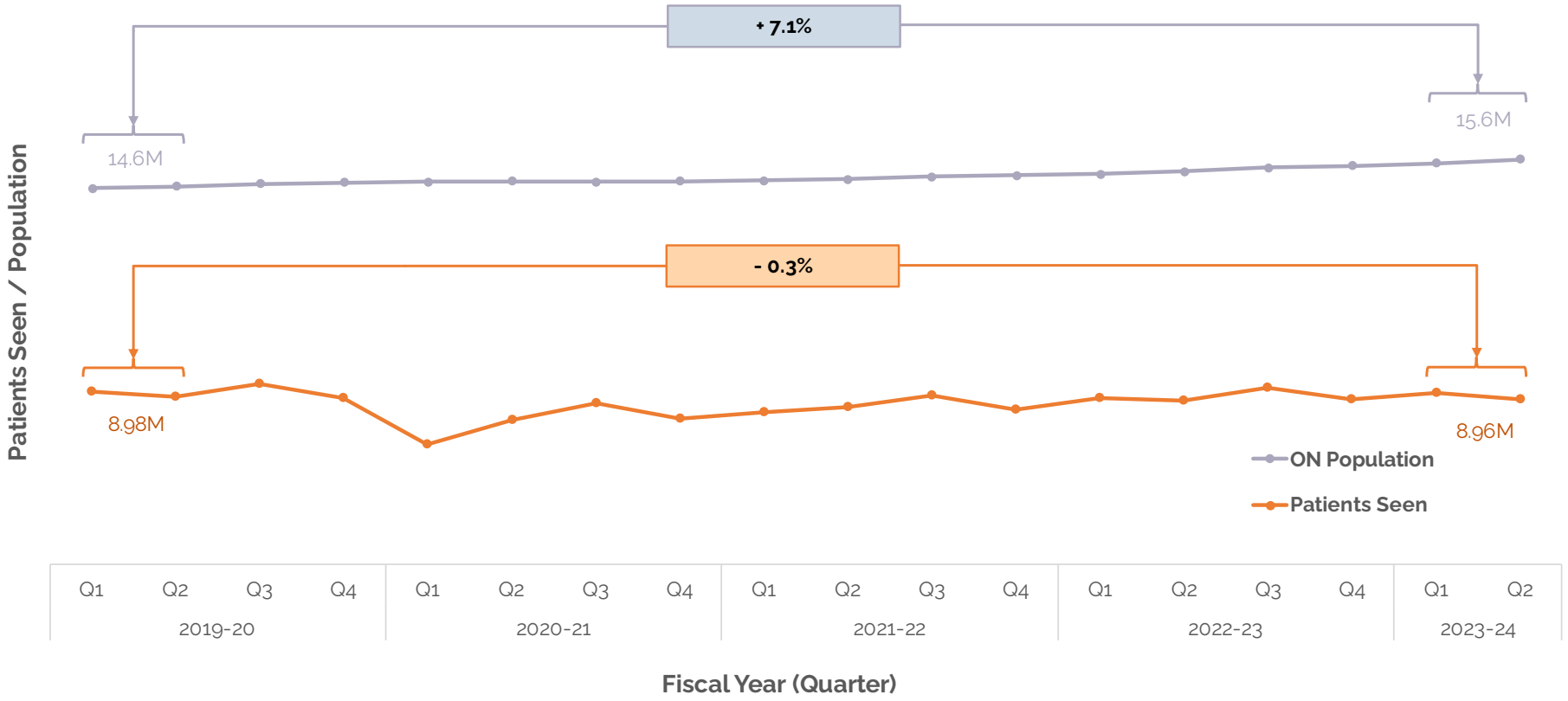
248. The growth in physician expenditure is not due to increase in population growth. Although the population increased by 12.5% between 2016/2017 to 2023/2024, again, over the same time period, the total growth in the distinct number patient seen by physicians only increased by 5.9%.



249. When narrowing the time period analyzed to the year before the impact of COVID, the evidence demonstrates that the population increased by 7.1% between 2019/2020 to 2023/2024, yet over the same time period, the total growth in the distinct patient visits for physicians only increased by 1.9%.



250. Focusing the analysis to primary care physicians, the results stand out for consideration and reflection even more. From 2019/2020 to 2023/24, the number of distinct patient visits by primary care physicians actually decreased by 0.3%.



251. A further historical pattern from 2005/2006 with respect to this is attached at **Exhibit 15**.

(e) Ontario Patients have Lesser Access to Physicians than they did in 2016/17 (when measured per physician)

252. While the total number of distinct patients seen per physician grew nominally between 2016/2017 to 2023/24, when accounting for the increased number of physicians over that period (increased supply), the average Ontario physician decreased the number of distinct patients seen by 9.1% over this time period.

Quarter	Avg. Distinct Patients Seen per Physician in 2016-17	Avg. Distinct Patients Seen per Physician in 2022-23 or 2023-24	% Difference from 2016-17
Q1	272	245 (2023-24)	**-9.6%**
Q2	256	233 (2023-24)	**-8.8%**
Q3	268	247 (2022-23)	**-7.8%**
Q4	263	237 (2022-23)	**-10.0%**
Average Across All Quarters	**265**	**241**	**-9.1%**

253. When reviewing the 2019/2020 to 2023/24 time period specifically, physicians decreased the number of distinct patients seen by 5.9%.

Quarter	Distinct Patients per Physician in 2019-20	Distinct Patients per Physician in 2022-23 or 2023-24	% Difference from 2019-20
Q1	263	245 (2023-24)	**-6.5%**
Q2	250	233 (2023-24)	**-6.8%**
Q3	263	247 (2022-23)	**-6.0%**
Q4	247	237 (2022-23)	**-4.1%**
Average Across All Quarters	**256**	**241**	**-5.9%**

254. The results are even more significant when the focus is narrowed to primary care physicians. From 2019/2020 to 2023/24, the average primary care physician decreased the number of distinct patients seen by 7.7%.

Quarter	Distinct Patients Seen per Physician in 2019-20	Distinct Patients Seen per Physician in 2022-23 or 2023-24	% Difference from 2019-20
Q1	465	427 *(2023-24)*	**-8.1%**
Q2	439	405 *(2023-24)*	**-7.8%**
Q3	472	430 *(2023-24)*	**-9.1%**
Q4	435	411 *(2022-23)*	**-5.6%**
Average Across All Quarters	**453**	**418**	**-7.7%**

255. A further historical pattern from 2005/2006 with respect to this is attached at **Exhibit 15.**

(f) The Average Ontario Physician is Having Fewer Patient Encounters in 2023/2024 than they did in 2019/2020

256. When reviewing the period 2019/2020 to 2023/24, the average patient encounters per physician dropped 3.7%. For clarity, the average "patient encounters" is a different measure from the earlier tables which captured "distinct patient seen." Patient encounter is a reflection of the number of patient visits a physician undertook in a year, as compared to the number of "distinct" or unique individual patients a physician saw in a year.

Physician Headcount (2019/20)	Physician Headcount (2023/24 Proj.)	Change in Headcount (%)	Avg. Patient Encounters per Physician (2019/20)	Avg. Patient Encounters per Physician (2023-24 Proj.)	Change in Avg. Patient Encounters per Physician (%)
33,250	36,204	8.9%	3,722	3,584	-3.7%

257. The evidence for family physicians is even more dramatic. The average patient encounters per family physician dropped 6.1% over this time period.

GP Headcount (2019/20)	GP Headcount (2023/24 Proj.)	Change in Headcount (%)	Avg. Encounters per GP (2019/20)	Avg. Encounters per GP (2023-24 Proj.)	Change in Avg. Encounters per Physician (%)
15,392	16,501	7.2%	3,935	3,694	-6.1%

258. A further historical pattern from 2005/2006 with respect to this is attached at **Exhibit 15.**

(g) Conclusions:

259. To summarize: while physician supply and physician incomes are increasing the opposite is true in respect of patients being seen. That has steadily declined. In fact, the total number of patient visits per year has decreased for the average physician.

260. It is concerning that while physician incomes have been rising, and the number of physicians outpaces population growth, patient access appears to have worsened. The irrefutable fact is that the number of distinct patients seen and average encounters per physician has decreased between the years 2016/2017 to 2023/2024. These results appear counter-intuitive.

261. This takes us to answering a number of questions given the evidence note above:

1. Does increased income incent increased services? The above facts would suggest the opposite.

2. Is the ultimate solution to improving patient access to add significantly more physicians? While there has been significant growth in the number of physicians (far higher than the rate of population growth), patient access has not improved.

3. Why are the number of physicians increasing, yet physician services decreasing? It could be the desire by physicians for greater work-life balance. Given physicians are independent contractors, unlike an employment setting, it is not within the control of government to set physician hours of work.

12.2 "The Induced Productivity Decline Hypothesis: More Physicians, Higher Compensation and Fewer Services"

262. Given the above counter-intuitive findings of increased physician supply and decreased access, we review the 2021 research paper of, among other researchers, noted neonatologist and health economist Dr. Shoo K. Lee entitled "The Induced Productivity Decline Hypothesis: More Physicians, Higher Compensation and Fewer Services." (Exhibit 16)

263. The researchers of the paper had noted the same puzzling trend that the above MOH data observes, as excerpt directly from the paper:

> Public outrage regarding physician shortages during the past two decades have led to policies aimed at significantly increasing physician supply, yet access remains elusive. In this paper, we examine this puzzling trend and the causes underlying it by analyzing physician supply, compensation and productivity and the reasons behind productivity decline. We hypothesize that excess physician compensation beyond a target income induces productivity decline.
>
> **In contrast to a wage–productivity gap for the average Canadian worker (where productivity has increased but compensation has not kept pace), physicians are experiencing a "reverse wage–productivity gap" whereby compensation is increasing but productivity is decreasing, resulting in more physicians, higher compensation and fewer services**.
>
> We conclude by discussing potential policy options to address how best to provide timely access to medical care for Canadians while keeping physician healthcare expenditures at sustainable levels.
>
> *[Emphasis added]*

264. The key findings of the paper are outlined below, as excerpted directly from the paper:

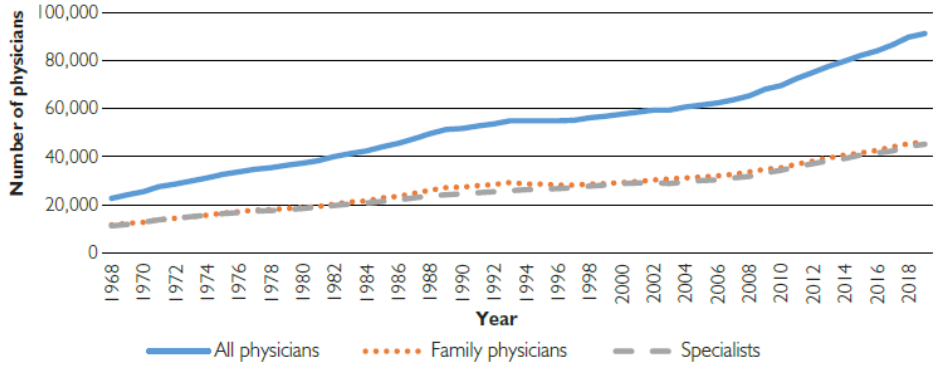
> Physician Supply has increased significantly. However, expected increase in physician service provision has been offset by dramatic decrease in physician productivity. The result has been a net increase in total physician services of only 0.2% per annum from

> 2013 to 2018. With Canada's population growing at just over 1% per annum, this translates into a net decrease of 5% in services per capita between 2013 and 2018.
>
> **Our results support the "induced productivity decline hypothesis," whereby excess physician compensation beyond a target income induces productivity decline, i.e. physicians reduce services when compensation exceeds their income targets.**
>
> *[Emphasis added]*

265. We review below the important evidence relied upon by the researchers in their findings as it relates to the supply of physicians:

> Physician supply in Canada has fluctuated over time. In the 1980s and early 1990s, there was a perceived surplus of physicians (Barer et al. 1991; Chan 2002b), leading to policies to restrict physician supply in the 1990s (Barer et al. 1991; Malko and Huckfeldt 2017). Within a decade, public outcries regarding poor access to physicians and long wait times led provincial governments to reverse course and significantly boost physician supply through increased medical school enrollment and recruitment and retention strategies for foreign medical graduates (Malko and Huckfeldt 2017), especially in underserved areas.
>
> **The increase in supply has led to the highest ratio of physicians per capita ever recorded in Canada (2.41 physicians/1,000 population in 2019 [CIHI 2020a]), with a growth rate more than double that of the Canadian population over the last five years (see Figure 1), and especially high in urban settings (CIHI 2020b).**
>
> Yet Canadians continue to express concerns about obtaining timely medical care, particularly from family physicians (FPs) (Brend 2017; The Canadian Press 2019).
>
> **In international rankings, Canada and Norway rank the lowest for same- or next-day appointments with a doctor or nurse (Schneider et al. 2017).**
>
> To address these concerns, it is critical to understand why the increase in physician supply has failed to meet the public's medical care needs.

FIGURE 1. Physician supply (1968–2019)



International comparisons of physician supply

The ideal physician-to-population ratio in developed countries has been difficult to define. For example, physician-to-population ratios in Canada remain low compared with other developed nations. According to Organisation for Economic Co-operation and Development (OECD) data in 2016, Canada ranked 24th of 31 countries (2.6/1,000 population vs. an average of 3.4/1,000) in physician-to-population ratio, including medical interns and residents.

Interestingly, however, the FP-to-population ratio in Canada is higher than the OECD average (1.3/1,000 vs. an average of 1.0/1,000, ranking Canada eighth), whereas the specialist ratios are lower (1.4/1,000 vs. an average of 2.2/1,000, ranking Canada 28th) (OECD 2020a).

This may derive, at least in part, from Canada's deliberate policy to have FPs act as "gatekeepers" to the healthcare system and to use specialists mainly as consultants rather than primary care providers. Regardless of whether this is an appropriate policy, the physician-to-population ratio in Canada has never been higher, and the number of FPs per capita is higher than in most OECD nations. Although many health systems in developed countries are similar to Canada's, they may differ in the way they are funded, which may impact health system outcomes differently.

[Emphasis added]

266. We excerpt below the important evidence relied upon by the researchers in their findings as it relates to the reduced productivity of physicians:

Productivity is key to the labour market, and physicians are no exception. For the purposes of this paper, physician productivity is defined as the number of patient services provided per physician per annum. In Canada, different fee for service (FFS) models, alternate payment plans (APPs) and salary and blended arrangements exist within and among provinces.

Ariste (2015) reported that in the FFS model, the volume of services per physician decreased at an average annual rate of 0.6% from 2004 to 2010, indicating that physician productivity had fallen.

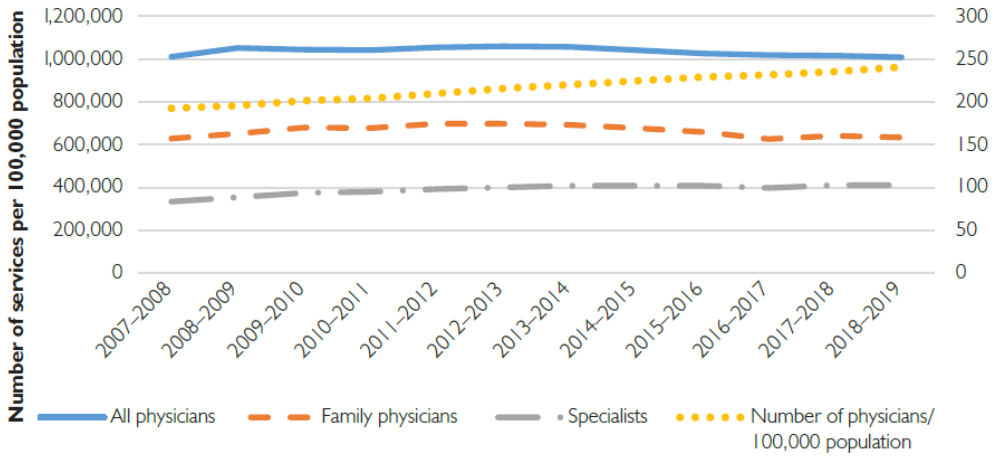
PHYSICIAN SERVICES PROVIDED PER CAPITA

Our results show that the number of physician services provided per capita (FFS and APP) has fallen by 5% despite a 7% growth in the number of physicians per capita during the past five years, from 2014 to 2019 (Figure 2) (CIHI 2020c).

The decline in total number of services provided was the greatest among FPs at 9% compared to an increase of 1% for specialists during the same five years.

The pattern was similar over a 10-year period from 2008 to 2018, with the number of physician services per capita falling by 4%, while the number of physicians grew by 37%.

FIGURE 2. Number of services versus number of physicians per 100,000 population



Between 2013 and 2018, the number of services provided per physician (FFS and APP) decreased by 13%, with the decrease

> **being greater among FPs (–16%) compared to specialists (–8%). Similarly, over the 10-year period between 2008 and 2018, the number of services provided per physician decreased by 23%, with the decrease greater among FPs (–21%) than among specialists (–4%) …***[Emphasis added]*

267. We also review below the important evidence relied upon by the researchers in their findings as it relates to the compensation increases of physicians:

> Physician compensation: International comparison
>
> **In a recent study of healthcare spending in 10 high-income countries, Papanicolas et al. (2018) reported that Canadian physicians are well compensated compared to other countries. Not including the US, FPs in Canada earn more than FPs in any other country except for Germany, while specialists rank only behind those in Australia and the Netherlands** (Appendix 1: Figure A3, available online at longwoods.com/content/26655).
>
> **In addition, among the 31 OECD countries, Canada has some of the highest ratios of physician-to-average–worker income at a ratio of 3.1 for FPs – second only to Germany and on par with the UK – and 4.9 for specialists, on par with France and higher than all other countries apart from Belgium, Chile, Luxembourg and Germany** (OECD 2019). The US was not included in the OECD analysis as physician compensation data were unavailable.
>
> Physician compensation growth in Canada
>
> CIHI data from 2019 show that the three largest health expenditure categories since 1975 have been hospitals (27%), physician payments (15%) and drugs (15%) (CIHI 2019).
>
> **Physician expenditure growth rates have consistently exceeded both inflation (adjusted for population growth) and GDP growth rates, except for a short period in the early 1990s (Figure 4). Between 1999 and 2018, the average gross FFS-based physician income for those earning above $60,000 increased from $210,812 to $332,233 at an average annual rate of 3.0% compared to the average annual inflation rate of 1.7% (CIHI 2019). Physician expenditure per capita increased by an average of 8% per annum from $408 in 1999 to $1,064 in 2019 (CIHI 2019).**
>
> *[Emphasis added]*

268. The researchers also reviewed the following evidence for the reasons of reduced productivity (excerpted):

> WORKING HOURS
>
> **Survey data from CMA's National Physician Health Survey from 1998 to 2019 (Figure 3) show that the total weekly working hours for physicians have declined by an average of 9% over the past 21 years (from 51.3 to 46.8 hours/week) (CMA n.d.).**
>
> SEX-BASED COMPARISONS
>
> **Male physicians report working longer hours than female physicians. Since 1998, there has been an overall decline in the number of weekly hours worked by both male and female physicians; however, the decline has been greater for men (11% vs. 2%) than women (Figure 3).**

FIGURE 3. Weekly work hours

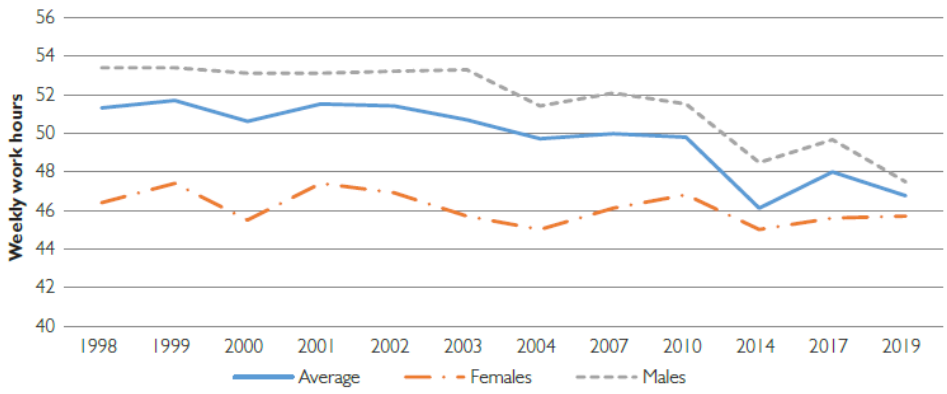


TABLE 1. Growth rate of weekly work hours by category (from 1998 to 2019)

Work activity	Growth rate (%)
Direct patient care	-12
Direct patient care without a teaching component*	-12
Direct patient care with a teaching component*	21
Health committees	-27
Managing your practice	-28
Indirect patient care	61
Research	-21
Administration	-42
Teaching	-10
Continuing medical education	-18
Other	-51

*Data for direct patient care with or without a teaching component are only available from 2004 to 2019.

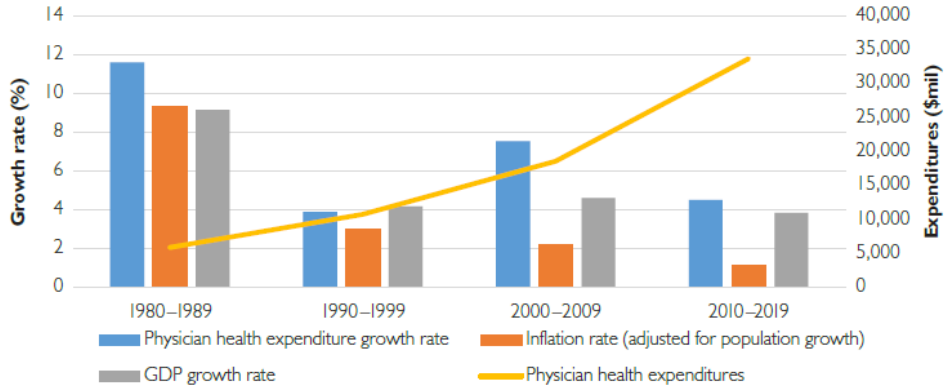
AGE

In 1998, the average number of hours worked by physicians increased with age until 65 years, after which it decreased. This pattern has since changed. Physicians of all age groups report reduced working hours (Appendix 1: Figure A2, available online at longwoods.com/content/ 26655); however, the decline has been greater as age increased until the age of 65 years (in comparison to 1998, the age groups in 2019 reported a decline in working hours of 1% for<35 years, 8% for 35–54 years, 12% for 55–64 years and 5% for 65+ years).

CATEGORY OF WORK ACTIVITY

Table 1 shows categories of physician activity as published by CMA's National Physician Health Survey. **Between 1998 and 2019, all categories of physician activity, except indirect patient care, decreased between 10% and 51%. Most significantly, direct patient care hours decreased by 12%, or 4.5 hours per physician per week, while indirect patient care hours increased by 61%, or 2.8 hours per physician per week.**

FIGURE 4. Physician health expenditure versus inflation and GDP growth rates



FPs VERSUS SPECIALISTS

Specialists consistently work more hours than FPs; however, both groups have reduced their working hours since 1998 by approximately 8% and 9%, respectively. In 2019, FPs reported working 46 hours/week compared to specialists who reported working 49 hours/week.

[Emphasis added]

269. The researchers than discuss the following important considerations and findings (excerpted):

Discussion

Our results show that after a brief slowdown in the early 1990s, physician supply has increased significantly, growing by 63% between 1998 and 2019, and more recently by 37% between 2008 and 2018, resulting in the highest physician–population ratio in Canadian history with 241 physicians/100,000 population by 2019.

However, the expected increase in physician service provision has been offset by a dramatic decrease in physician productivity (or services provided) by 23% per physician between 2008 and 2018. The result has been a net increase in total physician services of only 0.2% per annum from 2013 to 2018. With Canada's population growing at just over 1% per annum, this translates into a net decrease of 5% in services per capita between 2013 and 2018.

Our results support the "induced productivity decline hypothesis," whereby excess physician compensation beyond a target income induces productivity decline. It is a small wonder that public complaints about long wait times and difficulties with access to physicians have not abated (Brend 2017; Martin et al. 2018).

From the physician survey, we were able to discern the following, albeit an incomplete, picture. The reduction in physician services provided appears to be due to both decreased average physician work hours and changes in the types of work performed. Average physician work hours decreased by 9% or over 4.6 hours/week/physician between 1998 and 2019. The impact on service provision is further compounded by a decrease in direct patient care activities of 12% (or 4.5 hours/week/physician) between 1998 and 2019. In contrast, indirect patient care activities increased by 61% (from 4.5 to 7.3 hours/week/physician). The CMA defines indirect patient care activities as "reports, charting, patient or family phone calls" (CMA 2019b). Several advances in medical practice, such as electronic medical records, may improve documentation; however, they almost universally decrease productivity (Howley et al. 2015). Moreover, as the population ages and comorbidities increase, the patients' needs become more complex and require more time (CIHI 2011a; Pereles and Russell 1996).

The significant increase in indirect patient care activities merits further research to better understand why physician activities are changing, what value they provide to patients and how they are being compensated. Crossley et al. (2009) reported that increasing hours of direct patient care by 5% among currently practising physicians would have a greater impact on effective physician supply than large increases in Canadian medical school enrolments.

We also observed that between 2008 and 2018, the number of services provided per physician decreased by 21% for FPs and 4% for specialists. It is unclear why the decrease has been especially marked for FPs. It is possible that this may reflect the changing roles and scope of practice of FPs and specialists as medical technologies advance. Chan (2002a) and a CIHI study reported that FP service provision has become less comprehensive (Tepper 2004); that is, FPs are referring more to specialists for services that they would have performed themselves in the past.

Sarma et al. (2018) reported that capitation models (APP) among FPs lead to more specialist referrals.

The shift to virtual care in primary care practice during the COVID-19 pandemic on productivity will also need to be monitored once the pandemic is controlled (Glazier et al. 2021).

The reasons for decreased physician productivity are multifactorial and require further research. A major factor underlying decreased work hours may be a shift in attitudes of phy- sicians toward a better work–life balance with reduced working hours and an increased focus on earlier retirement (Malko and Huckfeldt 2017; Weizblit et al. 2009). This is particularly relevant among female physicians, who work fewer hours and take more personal leaves (Weizblit et al. 2009). It is also pertinent in the context of the increasing female enrollment in medical schools, where the male–female ratio has shifted dramatically from 60:40 in the 1980s (Burton and Wong 2004) to 44:56 in 2018 (CMA 2019a). However, male physicians have recently also reduced their working hours to approximate their female colleagues more closely, narrowing the gap from seven hours in 1998 to two hours in 2019. Another impor- tant change is the reduction in working hours of older physicians, who traditionally worked more hours than younger physicians. This has since reversed and may be attributable at least in part to the attitudes of a younger generation as they age in the workforce. A greater supply of alternative providers, the development of group practices and the evolution of practice networks have also likely decreased the need for many physicians to work longer hours.

Our finding of rising physician compensation even while physician hours and productivity have decreased is paradoxical. In a comprehensive study of physician compensation, Grant and Hurley (2013) reported that between 2001 and 2010, the average gross income of physicians increased at their fastest rate since the introduction of medicare – rising by 33% from $187,134 to $248,113 (Grant and Hurley 2013). Data from CIHI show that this has since increased to $332,233 in 2018, indicating that gross FFS-based physician income has grown at a faster rate than inflation over the past 19 years (average of 3.0% vs 1.7% per annum) (CIHI 2020c), which is unsustainable when healthcare costs consume an ever-increasing proportion of the GDP. Buys et al. (2019) reported that younger cohorts of physicians received higher annual gross incomes compared to older cohorts at the same age, despite seeing similar or fewer numbers of patients. A study by CIHI (2011b) also reported that growth in physician fees is a major driver that accounts

for over half (53%) of physician expenditure increases. At the same time, Ariste (2015) reported that services per physician in Canada decreased by 0.6% annually between 2004 and 2010, and we found that the number of services provided per physician on FFS decreased by 23% between 2008 and 2018, with a greater decrease occurring among FPs (−21%).

Some provinces have tried to reform primary care by trialling variants of the APP model using salaried, capitated or blended capitation variants, in part, to see whether these interventions improved care and cost efficiency compared to the FFS model.

In Alberta, primary care networks (PCNs) were established in 2005, with physicians receiving either FFS-based or capitated payments (Peckham et al. 2018), and have been shown to lead to decreased emergency department visits and hospital stays (McAlister et al. 2018), as well as better management of chronic diseases (Manns et al. 2011). However, several reviews of PCNs found an inconsistency in financial management and accountability (Peckham et al.2018), and it is unclear whether there is a relationship between outcomes and FFS-based or capitation funding models.

In Ontario, FFS-based physicians had higher productivity than APP-based physicians (Sarma et al. 2010), but through longer working hours and more time spent on direct patient care (Laberge et al. 2016), that is, financial incentives increased productivity. Marchildon and Hutchison (2016) reported that team-based capitation models provided better preventive care and chronic care management, although patient-reported outcomes were unchanged. Laberge et al. (2017) reported that enhanced FFS models using physician-based teams had the lowest primary care and total healthcare costs, whereas blended capitation models using multidisciplinary or physician-based teams were associated with higher primary care costs but lower total healthcare costs than FFS models. However**, the annual report of the Office of the Auditor General of Ontario (2016) found that the patient enrolment model is more expensive than the FFS model, and the Ontario Ministry of Health and Long-Term Care could not demonstrate whether the new models improved patient access, quality of care or cost-effectiveness**. Thus, primary care costs have increased with the reforms, although this may be offset by lower total healthcare costs per patient (Laberge et al. 2017). To date, various attempts to reform primary care have not led to sig- nificant changes in total physician expenditures.

In a recent study, Uguccioni (2016) described a “wage–productivity gap” in which median real hourly earnings grew by only 0.09% per annum for the average Canadian worker between 1976 and 2014, while productivity grew by 1.12%. The situation is reversed for physicians in Canada, where average gross FFS-based income increased by 20%, while productivity decreased by 23% between 2008 and 2018; that is, the price per service has increased significantly.

This “reverse wage–productivity gap” lies at the heart of the failure to increase physician services through increasing physician supply and compensation. It is possible that the “induced productivity decline hypothesis” is at play, with physicians reducing services when compensation exceeds their income targets.

It is also possible that governments are politically ill-equipped to deal with the monopoly power of physicians to set fee increases, and alternate strategies are needed to control physician expenditures.

Physicians have a right to work less, but compensation should be based on a combination of productivity, quality of care and outcomes.

Rising physician compensation also contributes to the increasing income inequality between the top 1% of earners and the average Canadian worker (Marchildon and Di Matteo 2014) and must be addressed by policy makers to ensure sustainability of the public healthcare system.

Finally, Canadian physicians are well compensated compared to physicians from other developed countries. Canadian physicians are among the best compensated in the OECD countries with reported data, with an average gross FP income of $163,000 (US$, Purchasing Power Parity [PPP]) (versus an OECD average of $127,000) and an average gross specialist income of $257,000 (US$, PPP) (versus an OECD average of $231,000) for self-employed physicians in 2016 (OECD 2020b). Canadian physicians also have one of the highest ratios of physician-to-average–worker incomes at 3.1 for FPs and 4.9 for specialists, ranking Canada second and fifth highest, respectively, among 31 OECD countries (OECD 2019). In addition, physician expenditure growth rates have consistently exceeded inflation and GDP growth rates, which is financially unsustainable for the publicly funded health- care system. To improve availability of physician services, it is imperative that

> governments understand the implications of the “induced productivity decline hypothesis” and address the physician “reverse wage–productivity gap” rather than rely on the current strategy of increasing both physician supply and compensation because it is not yielding the intended benefits and is financially unsustainable.
>
> *[Emphasis added]*

270. The researchers offer the following policy option in light of their findings (excerpted):

> Having examined physician supply, productivity and physician availability, we now discuss policies for managing physician supply and demand. Our analysis highlights the importance of simultaneously addressing the twin problems of physician compensation increase and productivity decline. As previous research has demonstrated that systems with higher rates of private financing are negatively associated with universality, equity, accessibility and quality of care (Lee et al. 2021), private financing of healthcare is not a solution. Physician expenditure increases should be constrained by principle-based criteria (e.g., no more than either the rate of inflation or GDP growth). Physician compensation should be linked to productivity and important patient-centred outcomes such as evidence-based care and health outcomes. Healthcare processes such as documentation and referrals should be automated and streamlined to improve productivity, and reimbursement for indirect patient care services should be based on value to patients. Physician productivity may be increased by greater use of extenders such as physician assistants. In the case of primary care, alternate care provid- ers, such as nurse practitioners and pharmacists, should be licensed and funded to practise independently. Primary care teams may improve care and reduce total health costs but their relationship with funding models is unclear and should be monitored and adjusted. Primary care fund-holding organizations based on geography could be employed to improve efficiency and distribution of physicians (Price et al. 2015).

271. For completeness, we also outline the limitations of the study (excerpted):

> **As APPs comprise 20% to 28% of physician expenditures, using “same fee assumptions” based on FFS service levels may be inaccurate. The data analyzed from the CIHI National Physician Database do not include anaesthesia, laboratory and imaging**

> **specialists, and services/capita calculations do not include data from Alberta or the Territories, which may bias the results.**
>
> Overhead costs of physicians were not available. Physician productivity measures are impacted by the value and mix of services provided, which change over time. Because the dollar value assigned to each service is determined through a bargaining process between the government funders and the medical associations at the provincial level, it may not reflect the true value that patients place on the services. Patient complexity is not measured in any of these databases, which varies widely by practice and location. Response rates for the CMA National Physician Health Surveys averaged 40% of a random sampling of 8,000 physicians across the country from 1998 to 2004 and 20% of all physicians between 2004 and 2019 and may not be generalizable to all physicians.
>
> *[Emphasis added]*

272. Again, we reiterate the key finding of the paper that:

> Although physician supply in Canada has increased significantly in recent decades, physician productivity has decreased, resulting in a net reduction of physician services per capita. At the same time, physician compensation has increased, resulting in a "reverse wage–productivity gap" of more physicians, higher compensation and fewer services, which supports the "induced productivity decline hypothesis."
>
> **The current physician supply and compensation strategies do not improve physician availability, are not patient-focused, are not financially sustainable and need to be addressed comprehensively at a policy level.**
>
> *[Emphasis added]*

12.3 "Long-Term Trends in the Work Hours of Physicians in Canada"

273. Here we now turn to review another relevant (2024) study that aligns with the Ontario's billing data noted above and the research paper authored by Dr. Shoo Lee viewed above. The paper is entitled "Long-Term Trends in the Work Hours of Physicians in Canada" (Exhibit 17) and is authored by, among others, Boris Kralj PhD, Rabiul Islam PhD, Arthur Sweetman PhD.

274. Interestingly, this study identifies a similar trend to the above. We quote directly from the study below:

> Physician work hours directly influence patient access to health care services and play a vital role in physician human resource planning, but the current understanding of work hour trends among physicians in Canada is limited. Changes in the work pat- terns of physicians can affect the effective supply of physician services and, subsequently, patients' access to care. Traditionally, physician workforce planning, and health workforce planning broadly, has focused on demographic considerations, evaluating the age and sex composition of the workforce to determine the supply required to replace retiring professionals.[1] Examples of such planning models in Canada include the Canadian Medical Association's Physician Resources Evaluation Template and the Ontario Ministry of Health's Assessing Doctor Inventories and NetFlows models.[2,3] **In absolute terms and adjusted for population, the existing physician supply is considered high compared with previous years, but people in Canada are encountering challenges in accessing physician services.[4,5] As seen in the United States, current difficulties may not stem from changes in physicians per capita (i.e., extensive margin) but rather from decreases in physician labour supply (i.e., intensive margin), specifically, the number of hours worked per physician and its impact on service availability.**
>
> Several explanations for the decline in hours have been posited, including that physicians
>
> - may be seeking improved worklife balance[6,7] or
> - are reducing work hours in association with increased remuneration.[8]

> Traditional planning models have primarily focused on the extensive margin. To enhance the effectiveness of these models, a broader range of behavioral factors that underpin labor market choices should be incorporated, including hours worked.[7,9,10]
>
> *[Emphasis added]*

275. We also excerpt below the very relevant results of the study:

> Table 1 depicts the characteristics of physicians in Canada over the past 3 decades. The proportion of female physicians doubled from 1987–1991 to 2017–2021, and that of self-employed and incorporated physicians tripled. The proportion of physicians with young children (aged ≤ 5 yr) declined, as did the percentage of married physicians. Mean hours worked per week by physicians — shown as a 3-year moving average in Figure 1 and reported at 5-year intervals in Table 2 — changed markedly during the sample period ($p < 0.001$). **The 3-year moving average of physician weekly hours worked dropped 13.5%, from 52.7 (95% confidence interval [CI] 50.6–54.8) hours per week in 1988 to 45.6 (95% CI 44.3–46.9) hours per week in 2019.** Weekly hours worked by female, and especially male, physicians remained fairly flat until the mid-1990s, although the overall average declined slightly as the proportion of female physicians increased (Figure 1). Starting around 1997, the average hours worked by male physicians declined markedly, although the rate of decrease fluctuated and the trend was not monotonic.

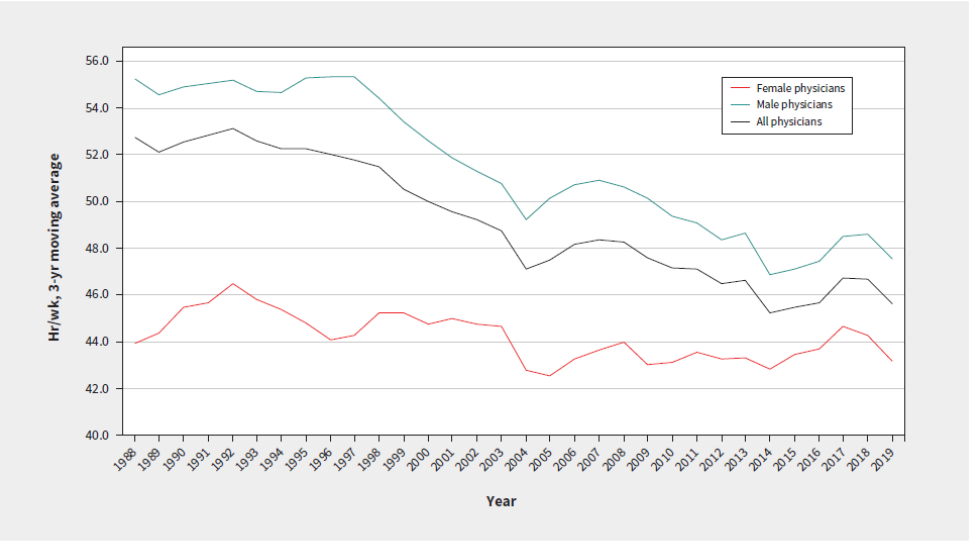


Figure 1: Three-year moving average of physician weekly hours worked, by sex.

Table 2 provides data on mean weekly hours worked across several physician characteristics. **Overall, the decline from 1987– 1991 to 2017–2021 totaled 6.9 hours per week or 13.0% ($p < 0.001$). Declines were recorded for both family physicians and other specialists ($p < 0.001$).** We observed no discernable differences in the declines in weekly hours for physicians in urban versus rural locations, those who were incorporated versus unincorporated, those aged 45 years or younger versus those older than 45 years, and those with versus without children aged 5 years or younger.

Trends in payment

During the 1990s, average physician payments on an hourly and annual basis were relatively stable, closely matching inflation (Figure 3). However, from about 2000 to 2010, physician pay-ments showed rapid growth, increasing by about 65% on an inflation adjusted hourly basis and about 45% on an inflation adjusted annual basis. Since 2010, inflation adjusted payments declined slightly on an annual basis and were close to flat on an hourly basis. The past 3 decades saw periods of both increased and stable average physician payments, even though the average weekly hours worked by physicians have consistently declined overall.

[Emphasis added]

276. The researchers provide the following interpretation on data for the decreased hours of physicians:

> Interpretation
>
> We observed that male physicians have been working fewer hours per week over the last 3 decades, representing a change in the intensive margin of physician labour supply. In contrast, work hours among female physicians have declined nonsignificantly. **Declining hours worked does not appear to coincide with a decline in earnings.**
>
> Medicine has historically exhibited a culture of long hours of work, with an expectation of round-the-clock availability, which has contributed to unhealthy work environments. Although we did not attempt to determine the causes behind the decrease in physicians' work hours, we propose that a shift in male physicians' preferences toward achieving better work–life balance is an important contributing factor. The question of whether these trends are related to physician burnout is relevant. Characterized by emotional exhaustion, depersonalization, detachment from work, and reduced personal accomplishment,[16–19] burnout can lead to negative effects on health, lower productivity, reduced work hours, and even exiting medical practice.[20] A **recent study of Ontario physicians cited improved work–life balance among the top 3 potential solutions to burnout.**[21] Even after the observed decline, compared with the entire Canadian workforce, physicians worked more hours per week. In 1987, workers aged 25 years and older who were employed full-time reported working 41.4 hours weekly in their main job; this declined by 4.6% to 39.5 hours by 2021.[22] Relative to other full-time workers, in 2021, physicians worked about 20% more hours per week. We speculate that, in part, the decline in working hours may be a response to burnout.[23]
>
> Declining physician work hours is not unique to Canada. Comparable trends exist in the United States,[24] where average weekly physician hours dropped 7.6% between 2001 and 2021, predominantly because of the decline in hours worked by male physicians,6 and in the United Kingdom, where average hours for gen-eral practitioners and hospital based physicians dropped by 25% and 21%, respectively, between 1998 and 2020.[25] **Similar observations in jurisdictions with different health care systems support our suggestion that these trends reflect a cultural shift, primarily**

> **among male physicians, toward more balanced home and work lives.**
>
> **Another potential explanation for the decrease in physician hours could be the impact of payment increases exceeding target incomes.[8] Like others, physicians make decisions regarding time allocation between work and other pursuits**. The effect of hourly pay raises on these decisions can vary depending on individual preferences, resulting in either an increase in working hours (substitution effect) or a decrease in working hours (income effect).[26] However, we found no evidence that increased physician payments and the resulting income effect contributed to reduced work hours. The decline in work hours occurred in periods of both rising and stable payments. The way forward will likely involve policy-makers increasing the size of the medical workforce — including physicians and other occupations involved in interdisciplinary care — faster than population growth to accommodate historical and potential future hour reductions (and increasing demand from an aging population).[10] Evidence documents an earnings gap between female and male physicians; in Canada, female physicians earn about 10%– 15% less than their male counterparts.[27] The convergence in hours worked by sex will need to be considered in policies aimed at narrowing disparities in pay by sex. The gap in pay should have narrowed with the gap in hours.
>
> More research is needed to establish the causes of declining hours and the resultant supply of physician services, as well as related changes in physician labour market behaviours, such as retirement ages.

277. We respectfully submit that the Ontario Experience, as well as the evidence of the two learned papers reviewed above, results in the following conclusions:

    1. Patient visits (and thus patient access) do not appear to be improved by increasing physician income.

    2. **Additional solutions** must be considered (including but not limited to team based care), in order to meet the Government policy objective of greater patient care and more attachment of patients to a primary care provider.

13. THE ABSENCE OF EVIDENCE OF INCREASING PATIENT COMPLEXITY

13.1 **“Trends in prevalence of chronic disease and multimorbidity in Ontario, Canada”**

278. While we have heard anecdotal observations that physician workload has increased significantly due to increased patient health condition complexity, this does not appear to be the case based on our review of the recent (2021) article entitled “Trends in prevalence of chronic disease and multimorbidity in Ontario, Canada” (**Exhibit 18**). All authors of the article are or were paid employees of the Ontario Medical Association. The study evaluated population trends in the prevalence of chronic disease, multimorbidity and overall patient resource intensity in Ontario, Canada, from fiscal years 2008/09 to 2017/18.

279. This study evaluates the prevalence of chronic disease and multimorbidity by estimating patient complexity using the CIHI Population Grouping Methodology (The Grouper). The Grouper contains a case-mix classification that profiles each person in the population using person-level demographic and clinical information. All persons in the population over a given time period, including healthy persons and persons who have not used the health system, are represented in the POP Grouper. There are over 15,000,000 rows of patients in the Grouper, with each row of the report representing one patient’s health data. The system maps patient diagnosis data from health care settings (physician claims, hospital stays, mental health facilities, long term care and more) to a set of 226 clinically meaningful health conditions, covering the full spectrum of acute and chronic morbidity. As such, complexity data is measured for every patient in the province. We would note that in the 2021 Physician Services Agreement, the parties agreed to adjust the current age-sex based capitation rates to include a new risk-adjustment model based on the Grouper.

280. Although listed as a limitation in the study, the authors state that the Grouper "permits a fuller accounting of chronic disease prevalence than many existing approaches."

281. The study finds that the total number of patients with chronic disease and multimorbidity increased over the study period (by 11% and 12.2% respectively). We excerpt directly from the paper below:

> The number of patients with chronic disease increased by 11.0% over the 10-year study period to 9.8 million in 2017/18, and the number with multimorbidity increased 12.2% to 6.5 million. Overall increases from 2008/09 to 2017/18 in the **crude prevalence** of chronic conditions and multimorbidity were driven by population aging.

282. In order to understand what crude prevalence means, we refer to the Statistics Canada definition of crude rates which is "expressed as the number of people or occurrences per 1,000 or 100,000 individuals in the population.[59]"

283. The absolute total growth in the number of patients with chronic disease (i.e. the 11.0%) or multimorbidity (i.e. the 12.2%) is almost entirely due to the growth in the population (which was 10.1% over the time period described).

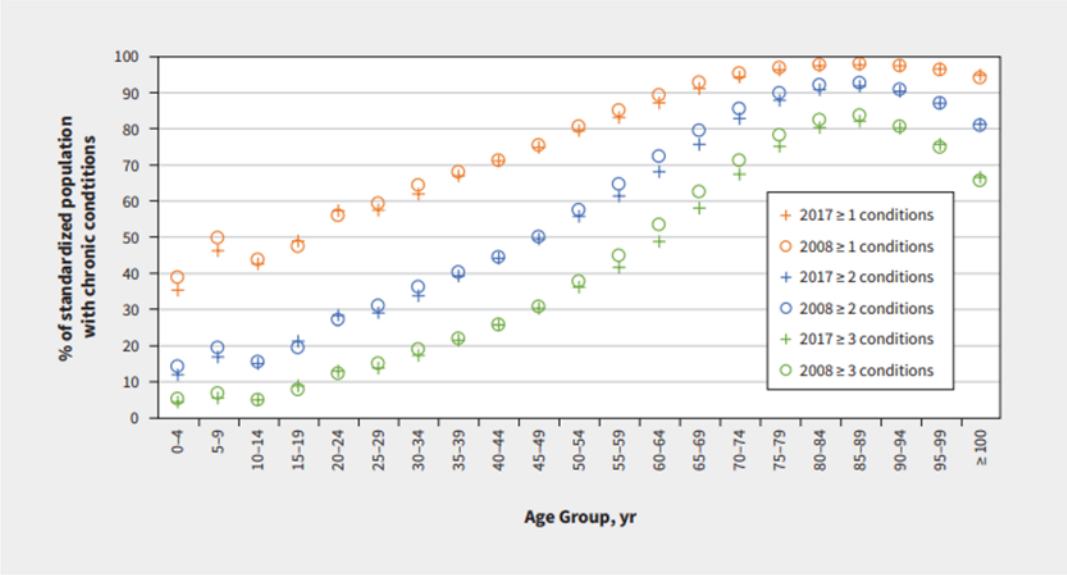
284. Further, after adjusting for age and sex, the prevalence of patients with one or more chronic diseases decreased from 70.2% to 69.1% and the prevalence of multimorbidity decreased from 47.1% to 45.6%.

> After adjustments for age and sex, the prevalence of patients with ≥ 1 chronic conditions decreased from 70.2% to 69.1%, and the prevalence of multimorbidity decreased from 47.1% to 45.6%.
>
> …
>
> Age- and sex-standardized prevalence of chronic disease declined slightly over the study period, as 70.2% had 1 or more chronic

[59] https://www.statcan.gc.ca/en/dai/btd/asr

> conditions in FY 2008 compared with 69.1% in FY 2017 ($p < 0.01$). Overall, multimorbidity also declined modestly. The prevalence of 2 or more chronic diseases in the standardized population decreased from 47.1% in FY 2008 to 45.6% in FY 2017; for 3 or more chronic diseases, the prevalence decreased from 31.3% in FY 2008 to 29.9% in FY 2017 ($p < 0.001$).
>
> …
>
> Changes in the prevalence of patients with ≥ 1 major chronic conditions and ≥ 1 other mental health conditions were not statistically significant.

285. Further, the study finds that for many of Ontario's most prevalent age cohorts (i.e. 45 – 70) multimorbidity has decreased. We excerpt the following chart from the article which demonstrates this below:



286. The authors conclude that they "did not find the same sharp increase in chronic disease in recent years that was noted in previous studies from Ontario."

14. HEALTH SYSTEM TRANSFORMATION

14.1 Transformational Solutions to Make Health Care Access More Convenient

287. The Ministry has made progress in improving access to health care services. As will be submitted below, Ontario's plan includes utilizing the engagement of a broader team of care providers including Nurse Practitioners, Pharmacists and Social workers, to name a few. Ontario has skilled and qualified resources that have started and will continue to be utilized to support and care for Ontario's patients.

288. First, the Ontario Government has and continues to invest in new and expanded interprofessional care teams. On February 1, 2024, the Ontario Government announced an investment of $110 million to primary care teams in 2024–25[60]. In the 2024 Budget, the Government built on this investment, and outlined a total investment of $546 million to primary care teams over three years, starting in 2024–25[61]. This funding will support connecting approximately 600,000 people to team-based primary care through new and expanded interprofessional care teams. This builds on the 2023 Budget commitment of an additional $60 million in funding, bringing the total investment to $606 million since 2023/24.

289. This significant investment supports connecting Ontarian's to a range of team-based primary care which includes Nurse-Practitioner-Led Clinics, Family Health Teams, and Indigenous Primary Health Care organizations. These interprofessional teams connect people to a range of health care providers, which include doctors, but also include nurse practitioners, registered and practical nurses, physiotherapists, social workers and dietitians, among others.

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[60] https://news.ontario.ca/en/release/1004143/ontario-connecting-over-300000-people-to-primary-care-teams

[61] Ontario, "2024 Ontario Budget: Building a Better Ontario", at p. 84 [2024 Ontario Budget] (Brief of Exhibits, Tab 9).

290. Nurse Practitioner-Led Clinics ("NPLC"s) were created to provide comprehensive, accessible and coordinated family health care services by targeting Ontarians who have difficulty accessing primary care. NPLCs are funded for a lead Nurse Practitioner (NP) and a team of interdisciplinary providers such as nurse practitioners, registered nurses, registered practical nurses, social workers, registered dietitians, pharmacists, and health educators, among others. In this model, **the NP's are the Most Responsible Primary Care Provider**, with a collaborating physician participating. NPLCs are contributing to improving Ontarians' access to comprehensive primary care by promoting faster access to the right care through house calls and same-day or next-day appointments. They provide health promotion and disease prevention programs and services, including cancer screening, nutrition, smoking cessation, and diabetes programs. They also collaborate with other community partners in the delivery of person-centred programs and services. The Ministry currently funds 25 NPLCs**.**

291. Family Health Teams ("FHT"s) are team-based models that include groups of physicians working alongside inter-professional health care providers to deliver comprehensive and coordinated primary care to patients. In addition to physicians and physician groups, FHTs can include nurses, nurse practitioners, social workers, dietitians, health promoters and others. Their mandate is to provide community-based primary care services and programs in the areas of health promotion, disease prevention and chronic disease management. FHTs also contribute to provincial and local priorities in the areas of access, quality and service coordination. The Ministry currently funds 182 FHT's.

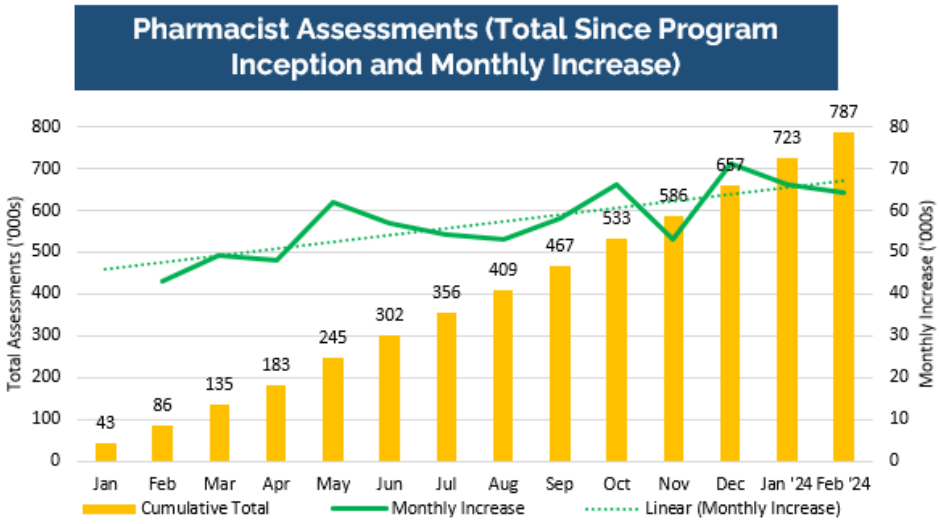
292. Indigenous Primary Health Care Organizations ("IPHCO"s) are Indigenous-led, primary health care organizations that provide a combination of traditional healing, primary care, cultural programs, health promotion, community development initiatives, and social support services to First Nations, Métis and Inuit communities. IPHCOs are closely modelled after Ontario's Community Health Centres and provide the mechanisms to improve the health and well-being of

populations facing various barriers in accessing health care. The Ministry currently funds 21 IPHCO's in the province.

293. Investments have also been made in increased primary care services such as the minor ailments program wherein Ontario Pharmacists are able to prescribe certain medications for minor ailments. Initially, Ontario pharmacists were authorized to prescribe certain medications for 13 minor ailments. Then, in October 2023 the program was expanded to include an additional 6 minor ailments. Minor ailments are short-term health conditions that can be managed with minimal treatment and/or self-care strategies (e.g., dermatitis, pink eye, canker sores, etc.).

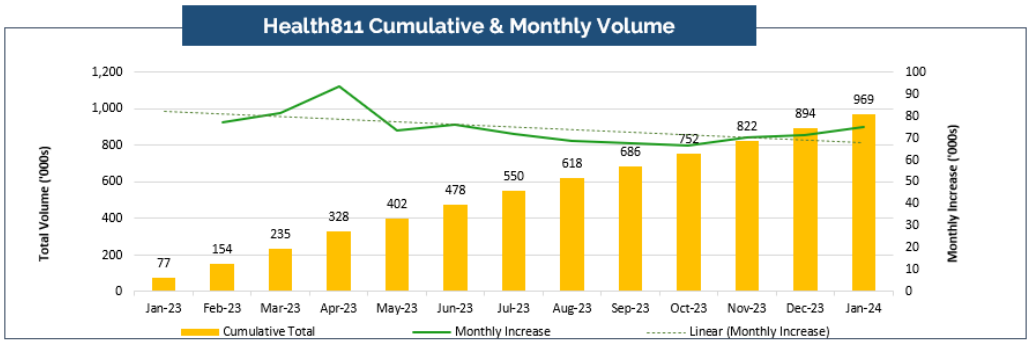
294. The minor ailments program helps support people in their communities by providing convenient access to the right treatment through their local pharmacies. Enabling minor ailments to be treated by pharmacists, who are available during retail hours including weekends and evenings, allows physicians to focus on more complex cases, levering their full scope of practice.

295. We provide below the total number of pharmacists assessments since the program inception. There have been more than 787,000 pharmacist assessments for minor ailments up to February 2024, with more than 5700 pharmacies having participating in the program (96% of pharmacies in Ontario).



296. Providing help to Ontarian's to navigate the health system, such as investments in Health 811. Health811 provides Ontarians with 24/7, online and over-the-phone access to a registered nurse for health care advice that helps keep people at home and out of emergency departments. Health811 monitors patient journeys, demonstrating how effective the program is at keeping people out of inappropriate care settings, such as emergency departments, and safely supporting them at home. When patients are able to safely access care from home through Health811, primary care physicians can address more urgent patient care needs.

297. Within the program's first year of operations (April 2022 – April 2023) over 196,000 patients did not seek care in emergency departments after connecting with Health811. As the table below shows, the Health811 program sees almost 1 million connections (e.g. phone calls, virtual chats) per year.



298. The Ministry has also made progress in reducing physician non-clinical time and thereby increase physician time with patients. Such initiatives were described in the section above regarding administrative burden.

CONCLUSION

299. Respectfully, the MOH brief provide facts and analysis from which one can draw the following conclusions:

1. The MOH position of an overall 3% increase to it's current 16.9 billion budget for physician compensation – an investment of $500 million - is comparatively fair and reasonable and is reflective of a "normal" increase for the period April 2024 to March 31, 2025 as that reflects the current negotiations trends where there is not a retention or recruitment issue.

2. "Catch-up" is not required for the previous settlement as the per physician average increase in physician income falls in the range of normative average wage increases in the public sector for the same period of time where retention and recruitment is not an issue.

3. Ontario does not have a Retention or Recruitment issue with its physicians beyond normative attrition rates in a workplace. The Ontario experience is that there are a significant number of people applying to medical school and that Ontario is the province of choice for residency following medical school. Ontario continues to have a superior fill rate for residency positions, including a 100% fill rate for family medicine, all while having increased the number of residency positions available. The evidence also shows that Ontario successfully retains family physicians, as the number of family physicians in Ontario has continued to increase year over year. This is not surprising, given that the analysis submitted to this arbitration board shows that the primary care model of choice (the FHO) is the best renumerated model in comparison to any other Canadian jurisdiction, even after the recent compensation changes made in other jurisdictions.

4. The administrative work within ones medical practice is not new, but the concept of a "administrative burden" advanced by the OMA is a new issue

to bargaining in this round and ought to be addressed with system reform, with physician input, rather than through compensation that incents paying for administrative time over clinical time with patients. First, it is too early in this issue's tenure to make such a conclusion and it would have the dilatory effect of incentivising pay for non-clinical work. Instead, the matter should be addressed by solving the problem. The MOH and OMA have started their efforts in that regard. For example, the MOH and Government are pushing forward on ereferral programs, eliminating forms (including sick notes), and the rapid beta testing of technological changes (consistent with some of the programs that physicians have already adopted individually within their own practice) which have shown impressive opportunities for significant administrative time reduction improvement. Additionally, the MOH and OMA will be engaged in extensive bargaining for the next three (3) years of this agreement. This will enable the parties to focus on this new issue relaying to administrative time and bilaterally explore ways to bring about change to reduce administrative burden which will result in more clinical care and income for physicians and positively impact their work life balance.

5. Physicians enjoy a unique and special contractual relationship in contrast to the traditional employment model. Physicians have significant discretion in the determination of their level of income, their hours of work and schedules, and as a result the number of patient's they see. They cannot be laid off by government and cannot be fired. They also have the unique advantage of earning the full price of a service as soon as they enter practice, and do not have to wait a certain amount of time or gain experience before reaching the full earning potential (unlike traditional employment models with wage grids or salary bands). Many of these advantages enjoyed by physicians as a result of their special contractual relationship with Government can increase overall compensation at the physician's discretion. The determination of this arbitration board must reflect this vast

difference between the unique Physician Contractor Model and the Traditional Employment Model.

6. Recent settlement trends capture the impact of the economy and inflation in Ontario and are therefore the best measure and benchmark for interest arbitration to measure the impact of the economy (including inflation).

7. Overhead is a business expense that can and has been addressed by revenue growth. Physicians have managed to achieve revenue growth in excess of price changes for many many years and we expect that to continue. There is lots of work in the health care space and lots of opportunity for physicians to continue their recent and longstanding success in achieving revenue growth above price.

8. Price increases will not solve the challenge of access to care in Ontario's health care system. Physicians are not expected to solve these issues alone and that is why Ontario's plan includes utilizing the engagement of a broader team of care providers including Nurse Practitioners, Social Workers and Pharmacists, to name a few. Ontario has skilled and qualified resources that have started and will continue to be utilized to support and care for Ontario's patients.

All of which is respectfully submitted,

On behalf of the Ontario Ministry of Health